UNIVERSITY OF ALBERTA

The Lived Experience of the Patient Care Manager

by

Georgina Fysh

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Education

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *The Lived Experience of the Patient Care Manager* submitted by Beverley Georgina Fysh in partial fulfillment of the requirements for the degree of Doctor of Education.

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Date: Sept 17/96

DEDICATION

This study is dedicated to nurse managers everywhere, and particularly to four special patient care managers who allowed me into their lives and who became my heroes.

ABSTRACT

This study seeks to illuminate midlevel management practices in one large acute care hospital by examining the experiences of four patient care managers. A narrative inquiry research strategy was used. Observation and interviews were used to compile field notes and elicit the managers' stories, which were then transcribed, reconstructed into a research text, and reviewed for meaning.

Commonalties in the experiences of these managers were found. The first commonality relates to the environment in which they work. Their work environment is fast paced and complex. The second commonality relates to the scope of their role which is vast and changing. They themselves are energetic, focused professionals with high expectations and confidence, who nonetheless have vulnerabilities and a need for support. Each of these commonalities is described using anecdotes and stories to search for meaning. Most did not anticipate or educate themselves for management roles. Recommendations for career planning and curriculum design are made.

The intent of this study is to share the documented experiences of these managers with others in the field. The sharing of the lived experiences of these four patient care managers, may encourage other nurse managers to relate their own experiences. This may result in a common base of knowledge about nursing management.

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CHAPTER 1

Introduction

> It is 6:30 a.m., dark and snowy, as I enter the hospital. As the manager on a nursing unit, I've come early today for a performance review with one of the staff. On the stairs to the basement where coat, boots and purse will be left, I think about the new policy for these distant lockers: no more handbags or coats on the floor. Staff, some of whom arrive with only minutes to spare, will be upset. Some may have to take an earlier bus. Or the time for morning report may have to be changed. Heading for the cafeteria for a take away coffee, I remember that a cashier who's liked by all (she lets those short of lunch money run a tab) is leaving soon. A gift should be discussed with the staff. But before I get my coffee, I'm paged. The night nurse tells me on the phone that someone saw me enter and there's an emergency on the unit. It's 6:40 now.

Purpose

The intent of this study is to illuminate management practices in one large acute care hospital by examining the lived experiences of a sample of mid-level management personnel known as patient care managers and describing their experiences as much as possible in their own words. In an attempt to understand their perspectives, the stories of the sample managers have been elicited, listened to and recorded during a six month investigation. Those stories will be reconstructed here with a focus on how those telling them try to make sense of their experiences.

> Hurrying to the unit, I find the resuscitation team in one of the bathrooms where a young patient who has overdosed has been found. No one knows where she got the drugs. Meanwhile the early morning routine (medications, insulin) has not begun. Extra staff have been requested but none have been found. I find the young patient stable, but looking vulnerable and pale. Her parents have been called. I speak with them, discerning their vulnerability

> too. They want answers. But I have none. The risk management team will investigate and review the incident report and chart. Someone extra is needed to sit with this patient, which will overrun the budget. When the extra nurse arrives, I give her a brief orientation, then meet with the physician and fill out a request for a psychiatric consultation. The performance review is postponed. The staff member to receive it isn't pleased. No wonder.

Narrative Beginnings

I am an educator now. But once I was a nurse manager, in a role similar to that of the participants in this study. So I have begun this text with brief accounts from one day in my life in that role for two related reasons. One is to illustrate the beginnings of my own reflections on an ongoing devotion to nursing management as a satisfying and challenging career. The other is to introduce and exemplify the methodological foundation of this study: narrative inquiry.

There are compelling reasons for using narrative inquiry. Connelly and Clandinin (1990) describe humans as story telling organisms who, individually and socially, lead storied lives, wherefore "the study of narrative is the study of the ways humans experience the world" (p. 2). These authors suggest that narrative and story generate a somewhat new agenda of theory to practice relations. One is looking to develop situations of trust where the story telling urge finds expression as part of the agenda. White (1980) says narrative helps to translate knowing into telling and can fashion human experience into human meaning that may even transcend cultures. Bruner (1986) considers this form of research as an art form that deals with the vicissitudes of human interaction (p. 16). Stories are powerful and compelling, says Bruner, especially if they can transform intuitions into

expressions in a symbolic system. Intuitions are a part of nursing; a sense of what one is about. According to Van Manen (1990), we may be able to recognize our lives in the mimicry of stories and conversational anecdotes, which can teach us indirectly what monologic text fails to (p. 144).

By relating the experiences of patient care managers through narrative inquiry, parts of their storied lives can be shared and the meaning, perhaps, enhanced and understood.

> Suddenly it's 1:00 p.m. I've made patient rounds, consulted with various doctors, talked to pharmacy and held a short team conference. But I haven't had morning coffee or lunch. Immediately ahead of me is a meeting on quality work improvement. I've great ideas on the concept, but don't know yet how to implement them. I pick up a sandwich to eat as we meet.

Statement of the Problem

The experience of being a manager for the organization of services for the provision of patient care in an acute care hospital is fast paced and complex. What is the experience of the patient care manager from the manager's perspective? If this experience can be reconstructed via narrative so that some shared conceptual understanding is reached, and is available to others, then the work of other managers may be enhanced, and so will the teaching of management to nurses.

Significance of the Study

Because I now teach nurses about management, I am seeking to learn the perspectives of those in health management positions and to be able to describe their understanding of their management practice. By reconstructing their narratives, I hope to achieve and make available to

students and managerial colleagues some shared conceptual understanding of the recorded experiences and views which might offer insight for future managers and provide a basis for curriculum design in postsecondary preparation programs. I believe my own teaching of nursing management will become much more "real" and much more "alive" than might have been the case had this work not been undertaken.

> I return to the unit at 3:00 p.m. The suicidal young patient has been transferred and a new one, an elderly gentleman, has been admitted in her place. He must be hard of hearing. Down the hall, a young intern can be heard shouting questions. I plan to speak with him about the handling of the elderly. Shouting doesn't help. One of the support staff asks for a particular week-end off. A nurse asks for help starting an I.V., as a previous one went interstitial and the patient is distressed. Time needs to be spent with him to reduce his overall anxiety too. As I drive home at 4:15, I make a mental list of the things to be done tomorrow that were missed today.

Information gathered will add to the body of nursing literature about the nature of the nurse manager activities from the perspective of the manager. The story of the day to day challenges of that position will be identified. A story, says Ricoeur (1983), is made out of a series of events. Successive action, thought and feelings presents certain directiveness to the reader, but the story's conclusion can be neither deduced nor predicted.

My own narrative, shared here, is riddled with feelings of vulnerability. The feeling of being "exposed to harm or criticism" (Oxford dictionary) is evident from the time one drives to work on a dark snowy day early in the morning with so little traffic about, to the moment when one wonders if help has come in time to save the young patient; or the moment when one realizes the time for sharing an important meeting with another, such as a performance review, has passed unfulfilled. Criticism may well come from

the overrun budget, or from the family of the patient whose I.V. is interstitial. There never seems to be enough time. . . .

By reconstructing this management experience, I hope to achieve some shared conceptual understanding with managerial colleagues. If I can describe how some patient care managers make sense out of their lived experience as a nurse manager, then perhaps their knowing as referred to by White (1980) will be told. Nurses will learn from understanding the meaning in the stories and other managers will see themselves in some of the stories. The stories related here may belong to any nurse manager who has been involved in similar activities. As shared meaning occurs, more cohesiveness and more understanding will be the outcome.

This study is significant from several perspectives. Jenkins (1991) makes the point that because the role of nursing management is grounded in a clinical discipline, it is sometimes difficult to determine if a nurse manager makes a difference to the practice of nursing. Therefore, the examination of the role of the nurse manager may lead to a model for the alignment of professional nursing practice and nursing management, according to that author.

A contribution to the field of nursing will come from identifying and describing the skills required for a patient care manager. Presently, says Dunham et al. (1991), management development for nurses comes from the business field rather than from looking inward to generate ideas about management development from nursing itself. The education of students for the role of nurse manager is part of most nursing curricula. A validated base

of knowledge about this role will help in planning a curriculum (Dunham-Taylor et al., 1993; Smith, 1993) to prepare future nurse managers.

As this leadership role becomes more and more critical in maintaining high quality care with severely constrained resources (Rozboril, 1987) it would be useful to know more about the skills involved for the purpose of both orientation and evaluation by the employing health care agency.

The significance of the study, then, might involve understanding the contribution of this role to the practice of nursing; a description of the skills to begin generating a management framework specific to nursing, validating a base of knowledge for the purpose of educating students; and assisting health care agencies to determine programs for orientation and evaluation. The most important significance, however, will be the shared feeling between the reader and the study participants, about the meaning of their lived experience.

The Health Care Environment

To set the stage for illuminating the work of the mid level nurse manager in one hospital organization, it is necessary to understand some of the turbulence surrounding the health care environment in the 1990's. For the first time since its inception (Rachlis & Kushner, 1994) Canada's health care system is in jeopardy. Criticisms about social programs desperately needing reform have been levied over the past five years according to Rachlis and Kushner, and while there seems to be general agreement that reform is necessary, there is no argreement about how health care reform might progress. The Federal government has off-loaded some responsibility on to the provinces and Rachlis and Kushner (1994) call for sensible criteria for

assigning roles for the federal and provincial government in health and health care. These authors point out that the 1990's in Canada have seen the country suffer the most severe economic downturn since the Great Depression, making the impact on federal and provincial treasuries severe. Provinces have responded to this fiscal crisis with across-the-board cuts to health care services, especially to hospital funding (Rachlis & Kushner, 1994). Since health services in Canada are primarily a provincial responsibility with a major federal influence (Sutherland & Fulton, 1992) each province can be directly responsible for priority setting, policy selection, planning, financing and delivery of any kind of health service (p. 54).

Within a framework of principles established by federal legislation, the federal government influences the health of Canadians. Certain services fall within federal jurisdiction such as healthy public policy. Health services in each province are influenced by the federal government by operating certain federally funded services such as health promotion, by deploying conditional grants and by deploying unconditional grants (Sutherland & Fulton, 1994). Steep cuts from the federal funding in reduced transfer payments to provinces (Caragata, Bergman, & Cardwell, 1995) have been one of the factors in the move to reform and restructure health care.

In Alberta, Ralph Klein's Tory government has imposed deep cuts to the health care system (Caragata, Bergman & Cardwell, 1995). A framework of health goals was produced by the Alberta Government (1993), targeting the use of health resources more effectively and efficiently (Alberta Health, Progress Report, 1993). The emphasis was to move away from institutional

care, and shift to health promotion, disease prevention and community care (Alberta Health, Progress Report, 1993).

Dramatic rollbacks in the rate of hospital funding put hospitals under a severe financial squeeze (Markham and Lomas, 1995). Variables affecting hospitals, according to Cercone, McDonald, Tarrant & Tremblay, (1994) include

- provincial health goals and priorities established by planning reports
- shift of emphasis from treatment to health promotion and disease prevention
- alternative means of delivery
- changing the types of services hospitals provide, and
- financial pressure on hospitals to reduce costs of care, to measure outcomes and to operate as efficiently as possible.

Hospital systems across Canada are now facing both bed and cost reductions (Roos & Brownell, 1994). Andrews, et al. (1994) write that the decade of the 1990's will become known in Canada as an era of transition, as health care services, which are highly valued by Canadians, undergo ongoing, inevitable and pervasive change. The restructuring of Alberta's health care system was enacted by the definitive step (Marriott, 1994) of authorizing the Regional Health Authorities Act. This act authorizes the creation of teams that will manage the new health system that was outlined by Alberta Health in 1994 (Marriott, 1994). Regional Health Authorities boards became a reality in Alberta in 1995.

The Contextual Environment of This Study

The hospital in this study is an 843 bed tertiary care academic medical centre located in Edmonton, Alberta. It is situated on the university campus but is autonomous from the university. As a major specialty care and referral centre for persons from northern Alberta, northeastern British Columbia, Northwest Territories, and Yukon Territory, it serves a population base of about 3 million people. Inpatient and outpatient services are provided in a very broad range of care. Employing about 6,000 people, high technological services such as organ transplantation and trauma programs are offered by highly qualified specialist physicians and other health care specialists (Andrews et al., 1994). The knowledge, skills, and commitment of the staff are manifested in breakthrough improvements in care, research papers recognized worldwide and annual visits by world health care leaders.

As the challenge of the 90s became one of demonstrating the unique value of the provision of patient care education and research, this hospital undertook to shape the future of the health care it provided by restructuring its organization. Key principles to shape the future involved accountability, teamwork, and empowerment, which is defined as having or having access to what is needed for fulfilling one's commitments within a defined role. Also involved is decentralized decision making at the most appropriate point in the organization, as developed through a shared governance model (Andrews et al., 1994). To make the organization even more flexible and responsive in the face of uncertainty and constant change, the overriding commitment of the restructuring is to shared decision making, collaborative governance,

governing councils, and professional accountability, moving managers from a directive to a facilitative role (Andrews et al., 1994).

The restructuring began in June 1993. Disciplinary divisions were eliminated and interdisciplinary teams focusing on care for particular groups of patients were created (Andrews et al., 1994, p. 115). There was no longer a Division of Nursing. Still committed to empowerment of staff and decentralized decision making, 40 management positions were deleted and 270 employees laid off. Those managers still employed found their work roles expanding as traditional ways of managing work divisions disappeared and managers became responsible for several areas. Feelings of knowing and security were replaced by those of loss, grief, overwhelming responsibility, and worry about the unknown.

Management activities have moved from directing and controlling to envisioning and planning, from acquiring budgetary resources to optimizing resource utilization, and from managing staff to leading and coaching (Andrews et al., 1994, p. 141). A shift in focus from tasks and toward competence in expected skills and behaviors (i.e., performance and capability development) is underway. Development of member capability, knowledge, skills, and commitment are expected. Customer satisfaction is to be the overriding goal. Total quality management is to be a guiding principle.

As a researcher wanting to study this new way of managing, I was privileged to be witness to these cutting edge reforms. One month of my field experience was spent becoming oriented to the contextual environment of the hospital, involvement in formal and informal meetings, discussions with many nurse managers, and the selection of four participants in this study. I

was able to sit in on many crucial meetings. Discussions with, and readings offered by, one of the hospital vice-presidents enlightened me further.

As one way to improve results in organizational practices and processes in this organizational transformation, a cost centre approach has been taken on budget control. This involves (a) clustering services around the patient, (b) enhancing the natural relationships of people working together, (c) keeping senior management closer to daily activity, (d) decentralizing decision making, (e) greater responsibility for resource utilization, and (f) reduction of management costs.

The resulting budget is a closed system because resources are limited to a set amount. However, it needs to be fluid enough to react to changing demands between areas of the hospital and to severity of cases (Andrews et al., 1994). The intent was that each unit should control the resources that are needed to provide services to the customer. Thus the lab should sell services to the patient care units or to the patient program. Support services are decentralized to each cost centre. Therefore, areas such as housekeeping, dietary aids, dietitians, respiratory technology support, rehab services, social services, and environmental services are no longer individual departments. The personnel of each now report to the patient care manager of the cost centre. Services still centralized include human resources, information systems and finance. A redefinition of work processes is ongoing, and in fact the reorganization of resources has not been totally accomplished. Since regional boards have become the authority which occurred in March of 1995, allocation of resources is under review.

These changes put nursing care delivery in the midst of chaotic and creative change (Murphy & Deback, 1991). A decreasing health care workforce is articulating and reshaping nursing practice (Strausen, 1989). The ranks of the mid level (Campbell, 1991) manager in hospital have been affected by major downsizing at that level (Strausen, 1989; Ponte & Capodilupo, 1992). The result of fewer numbers of mid level managers means an increased span of control, increased responsibility and authority (Strausen, 1989) broadened scope of practice, increased decisional roles and problem solving (Porter-O'Grady, 1991) and increased complexity of the role (Mark, 1994).

The mid level manager will play a critical role in the success of the change in organizational reform (Campbell, 1991; Mark, 1994). The involvement of this individual by providing education and information will enhance risk taking and participation toward overall success of any change.

Set in the midst of these transitions, then, are the mid level patient care managers in the hospital organization under study. This particular hospital is seen by the general public and health professionals as a benchmark hospital in the provision of care. The illumination of the kinds of activities undertaken by these patient care managers as the health care reform continues may aid in understanding of their work by other nurse managers.

This study has been organized into six chapters. The first chapter provides an introduction to the study and background information. The importance of shared understanding about the lived experience of a patient care manager is emphasized. The current health care environment is briefly discussed and the contextual environment of the setting is outlined. Chapter

2 offers a review of literature related to the development of nursing management in Canada, the influence of organizational theory on hospital and nursing management, and a review of research related to the teaching of nursing management. The methodology for the study is discussed in Chapter 3, concentrating on qualitative research and specifically on narrative inquiry as the strategy utilized for the study. Chapter 4 presents findings from the research of the lived experience of the patient care managers in the study. The common activities of each patient care manager are discussed under the headings; complexity and pace, scope of the role, and who are they?. The writing and analysis of the narrative is contained in Chapter 5. Each commonality is examined and discussed in synchronization with the literature. The final chapter, that is, Chapter 6, is called Reflections because it looks back—on the findings and on the methodology, and it looks forward—presenting recommendations for future extrapolations from the lived experience and for future research.

CHAPTER 2

Review of Pertinent Literature

The administrative role for the management of patient care in nursing services has undergone considerable transition over time. In this chapter, the development of this role in Canada is scanned from its predecessors in times of European settlement through the origins of the hospital head nurse to the current nurse manager role, with a focus on organizational structure and the influence of nursing practice on delivery of patient care within hospital structure. The influence of current health care reform is considered, the nature of nurse managers' work in the future is addressed by looking at current management practice studies, and literature on the use of narrative and storytelling in nursing education, especially in the teaching of nurse management skills and knowledge, is reviewed.

The Development of Nursing Management in Canada

Early hospitals in Canada were organized and run by religious orders from Europe. The first known to us came from France. French nursing sisterhoods, having crossed the Atlantic Ocean to the "new land", cared for native and European patients during illness, epidemics and wars. Mother Superior was in charge (Gibbon & Mathewson, 1947). The first hospital in Canada was the Hotel Dieu in Quebec, founded in 1639. Later, as civilization moved west, hospitals were established to serve settlers, traders, governers and military garrisons. Epidemics such as typhus and casualties from armed conflict were the focus of much of the care. Military hospitals were common

and were staffed by doctors, but nurses were on staff only occasionally and were called "Matron" when they were.

As the fur trade and farming flourished, settlements were established farther west and an order called The Grey Nuns, from Montreal, began a journey westward in response to a call from a Bishop concerned about an epidemic of cholera. Initially these sisters worked and lived in tents or crude housing, caring mostly for natives and Scottish immigrants during the epidemic. Across most of Canada similar pictures emerged. Settlements based on the fur trade, farming, fishing, logging and mining were growing, and the establishment of hospitals, both Catholic and Protestant, occurred as well (Gibbon & Mathewson, 1947).

In Alberta, the first public hospital was established in Medicine Hat in 1889 and was staffed by two nurses (Brighty, 1942), whose accounts perhaps tell of the beginning of nursing as we presently know it. The Matron of this hospital was Miss Grace Louise Reynolds, a graduate of Leeds, England, where she had trained under a Matron who had trained in turn under Florence Nightingale! Her assistant was Miss May Birtles, a graduate of the Winnipeg General Hospital whose words about those days have been recorded by Brighty (1942):

> Miss Reynolds and I managed the work between us. She prepared the meals and looked after the downstairs work; I managed the furnace and did the upstairs work, sweeping, dusting, etc., besides attending to patients. (p. 6)

Thus health care systems in pioneer Canada were greatly influenced by the nature of settler populations and by physicians who often came from a military background. General hospitals were often founded and maintained by religious orders and staffed by nuns and unpaid student nurses (Torrance,

1981, p. 255). As hospitals evolved from relatively simple, quasicharitable organizations to larger modern industries, their structure and technology grew (Torrance, 1981).

Although history rarely repeats itself, it is clear that similar problems in health care delivery emerge in different contexts across the years. Knowledge of the past, therefore, allows for a respect for that history and a certain degree of wisdom in searching creatively for new solutions while avoiding repetition of past mistakes (Storch and Meilicke, 1994, p. 33).

The Head Nurse Role

Terminology for those exercising managerial functions in nursing settings was somewhat variable during the formative years. In the period of settlement and of building and organizing early hospitals, it appears that nurses responsible for the administration and staff of hospitals were called "Mother Superior" if they belonged to a religious order, "Matron" if they were trained in England, and either "Charge Nurse" or "Head Nurse" if they were trained in Canada.

Mabel Holt (1936), superintendent of nursing at the Montreal General Hospital, has described the beginnings of hiring graduate nurses in hospitals, rather than staffing hospitals with student nurses, which was not common practice until much later in other parts of the country. Writing an account of staffing with graduate nurses for *The Canadian Nurse*, she tells of weighing the decision to increase the enrolment of the school of nursing or to hire graduates. The high unemployment rate of graduates at that time was the main reason the decision to do the latter was finally made.

A prescriptive formula for staffing was outlined by Superintendent Holt as well. It included, for what was termed a "typical" unit with 25 beds: one charge nurse, eight general duty nurses (six day and two night), two floats (one day and one night), two orderlies (one day and one night), and three maids for day duty. Where special nurses were hired by some patients, staffing was to be adjusted to meet the situation. A modified eight hour work day, rather than the twelve hour work day previously in effect, was adopted at the same time (Holt, 1936). Of most interest to this investigation, however, is the prescriptive outline for the duties of "charge nurse" this superintendent provides:

> The charge nurse, or Sister as we call her, is responsible for the administration of her ward and for the care of her patients. She makes rounds with the attending physician. She directs the nursing staff and assigns the patients for whom they are to care. The deputy charge nurse is responsible for these duties in her absence. (Holt, 1936, p. 8)

Apparently these changes were found to be pleasing to the public, the medical staff and graduate nurses themselves. It was seen to "benefit the nursing profession as a whole," reported Holt (1936). The editor of *The Canadian Nurse* in 1936, Ethel Johns, approved of it too. In an editorial about Holt, she described the innovation as an important experiment in staffing, adding:

> Here is proof that the authorities of one of the oldest and best of the Canadian hospitals have had the foresight and courage to seek a more excellent way.... This ought to put courage into the hearts and steel into the backbones of nursing administrators who have ventured to advocate this policy even in the face of powerful though sometimes unreasoning opposition. (Johns, 1936, p. 11)

There does not seem to be clear evidence, however, that hiring of graduate nurses in hospitals caught on quickly across Canada. What emerges instead is more evidence about the role of the nurse in charge. In 1939, three years after graduates began to be hired, more prescriptive routines for nurses in charge were reported in The Canadian Nurse. This time, though, the contibution was from a physician, referred to by the editor of *The Canadian Nurse* as "the distinguished Chief of Surgical Services" at the Montreal General Hospital.

Following the tradition of referring to nurses as "Sisters", this eminent physician, Dr. Henry, wrote (1939) that the "Sister in Charge" was expected to do all of the following: influence and teach the interns; be a specialist in procedures; be a "chemist", keeping up with "the many drugs, and dyes, and serums"; supervise intravenous machines; operate pumps; be a good bookkeeper and a "draftsman"; make special charts; and operate x-rays and slides for ward teaching. She was also expected to be: "a tactful executive", as were the attending staff men; a general superintendent of nurses and maids; and a go-between for dieticians and social service assistants. Finally, Dr. Henry adds, "our Sister's main purpose in the scheme of things is to look after and see that the patients are nursed!" (1939).

Although this account reveals the strong influence of physicians over nursing duties, Wheeler (1985) suggests that these early leaders in the field of nursing were neither servile nor lacking in knowledge. On the contrary: "Early nurse leaders were courageous women who dared to dream, to have vision and to struggle. Myths of early nursing leaders as subservient and

unknowledgable are clearly contradicted. Their work demands our respect and admiration... (p.33)."

The post war period saw many changes in hospital organization and procedure, including the introduction of auxiliary workers, which was a move to make the functioning of professional nurses more efficient (King, 1950), the introduction of secretaries or unit clerks (Henderson, 1970), and a move for reform in nursing education (CNA, 1968). Societal attitudes were changing. Young people were looking for new freedoms and breaking from established traditions. Authority was still recognized, but increasing confidence and personal freedom required changes in nursing. "Our increasingly permissive society is reflected in decreased restictions" (Dorwood & Tookey, 1968).

In 1961, the Alberta Minister of Health called a "Minister's Conference on Nursing" to discuss what was described as "the nursing team--our problem for the sixties". His invitation to a number of Alberta physicians, nurses, the Alberta Association of Registered Nurses (AARN), and the Alberta Hospital Association (AHA) included the statement that "Many factors have joined forces in the past decade to produce a problem that is causing great concern to all persons and groups concerned with hospital care" (Minister's Conference, 1961). The two day conference that ensued discussed the composition of the nursing team, the professional nurse, nursing aides, ward aides, orderlies, and financial responsibility. Concern about the role of the head nurse was expressed as well, reflecting a growing concern across Canada that head nurses were moving away from bedsides to spend too much time on non-nurse duties.

The result of the deliberations was that the role of the head nurse was redefined in light of the unit manager system. To demonstrate this new system, a pilot project was implemented in 1968 at the Montreal General Hospital. After a year of observation and study, a new role for head nurses was defined. The new position of unit manager was implemented too (Henderson, 1980). The latter was to coordinate non-professional care services. The former was to be an expert clinical practitioner.

The head nurse role, then, was changing. Team nursing, viewed by many as a panacea, was being stressed as the answer to the desire of many nurses to return to the role of providing nursing care as advocated by many writers of the time, the 1960s, though some writers (Howard, 1969; Goddard, 1965; and Douglas, 1965) took the opposite view. One director of nursing, who wrote a regular column in *The Hospital Administration Journal* during the later 1960s and the 1970s, was very definite in her advocacy of team nursing: "The job of nursing should be to nurse, and jobs other than nursing should be done by personnel other than nurses.... We achieve patient centered care through team nursing" (Germaine, 1971).

In the end, both team nursing and unit management were widely implemented in Canada during the 1960s and 1970s. In some hospitals, head and assistant head nurses were converted to team leaders, while in others, the head nurse role remained distinct and the role of team leader was rotated. Another influence began to shape nursing during these years too. Nurses' unions began to evolve in the 1960s and the 1970s and early 1980s; many head nurses were being given title changes to keep them out of bargaining units. The term manager became commonly used. Hibberd (1994, p. 578) writes

that first-line managers are excluded from the bargaining units in many jurisdictions by virtue of their managerial responsibilities. Conflicts of interest may arise if they are in-scope.

Throughout these years, there is evidence of resistance to change (McKillop, 1970), and particularly to the move toward decentralizing the authority of the head nurse role. Delegation of authority to permit more scope for the role of the nurse at the bedside was difficult, not only for head nurses relinquishing some of their authority, but also for nurses accepting increased responsibility and for doctors working with them. Other hospital departments, growing too, were also affected by the changes occurring within nursing.

> There was no longer just a laboratory, but several departments providing laboratory services. Meanwhile, nursing services, which represented 40-45 per cent of the total staff, were lumped together in one department. No one person could expect to be aware of all of the many needs of this complex group. (McKillop, 1970, p. 36)

The purview of the head nurse, then, changed considerably from the 1800s to the 1970s and 1980s. Once the only nurses in a hospital, nurses in leadership positions had to adjust to working with other nurses, being in charge of students and an assistant nurse, and eventually coordinating the work of auxiliary staff and a wide variety of other professionals. The relationship of working hand in hand with physicians changed too, as did the direct focus on patients. Hospitals and health care teams expanded. Administrative duties grew with them, requiring delegation of direct patient care to others. The transformation of old ideals into new realities is, and to some extent remains, therefore, the challenge posed by the transitions that have occurred.

The Influence of Organizational Theory

Review of Theories

Modern health care institutions are unique, complex, social institutions that function to some degree as bureaucracies (Sullivan & Decker, 1988; Tappen, 1995) which provide structure, well-defined policies and rules, and levels within a hierarchy of authority. Weber (in Etzioni, 1969) characterizes bureaucracies as having division of labour, hierarchy, rules and regulations, and technical competence. This is a structure which worked well in the past, according to Torrance (1981). As knowledge about organizational design and behaviour has grown, however, health organizations have considered, proposed and adopted a number of approaches to organization and management of work.

A number of well known theories (classical, neoclassical, technological, and modern systems theory) have impacted on the development of organizational work, hospital work included, over time. One of the cornerstones for organizational work in health care settings was provided by one of the classical theorists, Taylor (1911), cited in Sullivan and Decker. Taylor wrote about principles of scientific management which revolved around the elements of labour specialization, chain of command, structure of the organization, and span of control (Sullivan & Decker, 1988). That work was complemented by Fayol's, first published in French in 1916, which proposed five rules of management which came to be commonly utilized in organizations as the functions of management: planning, directing, organizing, coordination, and control. Both of these theorists emphasized the

management of personnel as the key to individual success (Urwick, foreword in Fayol, 1969).

Criticism of classical theory then led to neoclassical theory, which is often identified with the human relations movement of the 1930s (Sullivan & Decker, 1988). This school of thought added the dimension of social relationships, viewing people as desiring social aspects to their work time in organizations. This led to the advocacy of effort through mutual agreement (Mary Parker Follet, cited in Sullivan & Decker) or the idea of participative management. Neoclassic theorists attempted to humanize classical theory while maintaining a rational organizational structure, proposing the addition of cooperation, participation, and individual motivation to the structures of organization (Sullivan & Decker, 1988).

Modern systems theory, which developed from the 1960s onward, offered a framework for analyzing organizational behaviour and effectiveness. Researchers such as Woodward (1965), Katz and Kahn (1978), and March and Simon (1958) viewed organizations as complex sociotechnical systems operating on certain inputs to produce certain outputs in certain kinds of environments. This theory recognizes the vast complexities and the interactive effects of many variables in organizations, according to Sullivan and Decker.

Impact on Nursing Organization

Hospitals, which were already operating under bureaucratic structures, felt the impact of these theories, much of which was absorbed right into the workplace. The vertical dimension of hospital organization meant authority existed mainly at the top of the hierarchy and in middle management. Most

nurse managers worked below that level, attempting to coordinate and control the activity of functional work groups in order to carry out the directives of the top level executives (Sullivan & Decker, 1988).

In stable and predictable environments, centralized control permitted stable and predictable functioning within hospital organizations. Developments in research and technology, however, began to erode that stability and predictability of environments (Sullivan & Decker, 1988), while nurse managers remained responsible for providing high levels of care to patients. Managers were and are coordinators and mediators for staff, patients, and many others. Various models of nurse staffing have been utilized to organize the actual care of patients, and patient care delivery systems have been altered in an attempt to find the ideal one (MacPhail, 1988). Four major methods of organizing care have been identified in the literature.

One of the earliest identifiable methods for organizing patient care in hospital work was the functional system, in which work was assigned by task. Efficiency and cost control were the primary considerations. According to MacPhail (1988), this method was based on the work of Frederick Taylor, who viewed individual caregivers as requiring close supervision and constant direction. In this system, therefore, tasks were assigned on the basis of the abilities of each member of staff. The more difficult tasks were assigned to the more highly skilled, and the easier tasks to the less skilled, while the charge nurse had the authority, power and control. This system had limitations, however: care to patients could be fragmented, as several people might be involved in one or more aspects of care; nursing staff had limited

responsibility; and they had limited opportunity for making decisions too (MacPhail, 1988).

A method of work assignment designed to overcome the limitations of the functional method and to provide better continuity of care was the case method. Also prompted in part by the reduction of nurses' work hours from twelve to eight per duty day in the 1940s and 1950s, this method assigned one nurse a number of patients depending on the illness and the abilities of the staff. This was seen as a way to provide total patient care. But, while it allowed patients to be viewed and treated more holistically, this method left the charge nurse in central control, so nurses did not take total responsibility or learn to make decisions (MacPhail, 1988).

A third method of organizing staff to become widely used in hospital settings is known as team nursing. Influenced by a shortage of nurses during World War II, this method was developed to integrate nursing aides or nursing assistants into the process of providing patient care. It involves organizing both nurses, nursing aides and assistants and other staff into teams or work groups, which care for a number of patients as a group. Individual members of the team report to the team leader, who in turn reports to the charge nurse. This method was considered to improve patient care by utilizing the diverse skills of team members under the close guidance of a registered nurse. While it offered some opportunity for team members to enhance decision making skills, especially for the team leader, it still had the limitation of resulting in fragmentation of care.

Yet another system of care was created during the 1970s in an attempt to reduce the disadvantages of team nursing and to increase both nurse and

patient satisfaction (MacPhail, 1988). Called primary nursing, it was seen as "both a philosophy of care and an organization design....not simply a way of assigning nurse to patients, but rather a view of nursing as professional, patient-centered practice" (Hegyvavy, 1982, p. 3).

With this method, which was at one point widely accepted, one nurse was responsible for the care of one or more specific patients from admission to discharge, but made more decisions and exercised much more responsibility than with the case method. The chief advantages are continuity of care, increased nurse accountability, autonomy and authority, and total patient care (MacPhail, 1988). However, as MacPhail points out, it has been difficult to find a clear and definitive model for the implementation of this method. More often, combinations of the four methods of organizing nursing care are found.

An analysis of the major focus of each of these four methods was conducted by Giovanetti, 1986 (cited in Kerr & MacPhail, 1988). Functional nursing was found to focus on tasks, with accountability residing with the charge nurse. Case assignments were found to focus more on patients, with accountability still residing with the charge nurse. Team nursing was found to focus on both patients and managing team members, with ultimate accountability assigned to the charge nurse yet again. And primary nursing was found to focus on patients, with accountability flowing from one primary nurse to another.

The literature reveals, then, that the vast majority of nurses have had little influence in the history of the organization of the delivery of patient care. They have had little opportunity to make decisions at the bedside

either. Thus it should not be surprising if nurses have difficulty when such responsibilities are placed upon them, and nurse managers will need help in guiding them to accepting and handling such roles.

Nurses as Managers

The First Line Manager

As the practice of nursing developed and grew, terminology inspired by general organizational theory exerted growing influence over the profession. The more generic term of "first line manager" sometimes came to be applied to nurses responsible for the provision of care services to patients in hospitals. Leadership and management became common textbook titles (Marquis & Huston, 1992; Sullivan & Decker, 1988; and Douglass, 1992) as roles and functions of the nurse in charge became more generalized and increasingly complex.

The literature makes it clear that the term "first line manager" is used interchangeably with the positional titles "head nurse", "unit manager", and "charge nurse". Though the terminology differs from hospital to hospital and work to work, similar job descriptions are used in each case. Whatever it is called, the pertinent role is seen to have a dual focus (Duffield, 1991; Gillies, 1982), that is, a focus on both nursing care and management. The link between these two roles is seen as essential and pivotal (Duffield, 1991; Patz et al., 1991; Dunn & Schilder, 1993) and the nature of the role is seen as complex (Dunn & Schilder, 1993; Beyers, 1991; Morath & Manthey, 1993).

A research study by Beaman (1986), aimed at generating a clearer description of this role, examined tasks actually assigned to first line managers in one county in California. It was expected that a list of such

activities would help in the preparation of educational programs for first line managers. The questionnaire used in this study asked two questions: what managerial tasks were expected of first line managers; and do the expected tasks vary in hospitals of different size? Fayol's (1912) framework was used to identify thirty-one common tasks in the functional areas from that framework. Hospital size was found not to influence tasks.

A similar study, using a similar framework to identify head nurse tasks, was carried out by O'Neil and Gajdostik (1989). Using a nonprobability convenience sample of 68 head nurses and supervisors and a questionnaire, it asked respondents to indicate tasks essential to the nurse manager role. Like Beaman's (1986) study, this one identified the tasks of planning, organizing, staffing, communicating, controlling and decision making under the framework. Both studies suggested that these lists of tasks should help in developing educational programs.

A descriptive study by Dunne and Schilder (1993) used the triangulation methodology of interviews, questionnaires, observations and field notes to gather data from twenty subjects. Work activities were found to be "heavy and unpredictable". The volume, variety and pace of work activity on a daily basis were reported as being impressive and the challenges were described as "incredible", especially for novice head nurses. Strategies recommended for assisting these managers included clarifying expectations, providing frequent performance feedback, developing orientation and management education programs, assigning mentors, and providing opportunities for peer support.

The role of first level managers was examined by Patz et al. (1991) through a survey questionnaire designed to rank in order the characteristics

of effectiveness skills. Though this involves a change in focus, the findings of these researchers have added to knowledge about the nature of nurse managerial work overall as first level managers are key to effective unit operation. The results suggested that first level managers are more often immersed in actual clinical day to day care, while middle level managers are more involved in administration and less in clinical care. As others have done, Patz et al. suggest their work will be particularly useful in developing administrative educational curricula.

Patterns and sources of workplace stress related to the head nurse role were studied by Frisch et al. (1991) using semistructured interviews and a questionnaire about stressful events. A purposive sample of 21 head nurses from university teaching hospitals was used. Sources of stress and the explanations of them were grouped into three categories: control and uncertainty; concern about competence; and insufficient resources.

In another study of stress among nurses, Logan and Boss (1993) examined nurses' learning patterns, concluding that being "in charge" caused stress. Resolution of staff conflict and value clarification were found to be elements of the charge nurse role which caused nurses frustration.

A more complete look at the values of nurse managers was undertaken in a study by Smelzer and Vicario (1988), who first carried out a time and motion study of the role functions, then used a descriptive questionnaire to determine if the managers actually spent their time on the activities they valued. Strong values were described by the managers. Some, for example, claimed to value direct patient care and counseling patients' families highly.

Nevertheless, the findings indicated that often the time spent in activities was inconsistent with the values expressed.

Further issues faced by first line nurse managers were addressed in a literature review by Duffield (1991). Common agreement needs to be reached, she stressed, on the following points: the role of the first line manager as a clinician; role conflict; management skills and functions; requisite education to undertake the first line manager position; transition from clinician to manager; and boundaries of the role.

Some findings about the general nature of the first line manager role in nursing are provided in the literature, then, but are hardly comprehensive. Lists of identified tasks lack consistency from study to study. Sample sizes have been small, making generalization difficult. Issues and factors relating to stress have been considered, but need clearer formulation, particularly in light of current restructuring of hospital organization. Survey questionnaires have been the most popular methodology, but have usually asked respondents to rank or indicate agreement about predetermined activities or tasks, leaving questions about other tasks and activities unaddressed. Finally, there is doubt about the value of trying to quantify the first line manager role at all. As Stivers (1991) suggests, perhaps the element of caring cannot be translated into numbers and overrides all tasks.

The Mid Level Manager

The mid level manager holds the position between patient care and institutional operations. Nurses employed in this role are responsible for the operational, support and administrative components of hospital services necessary to provide care to patients (Sullivan & Decker, 1988). They are also

responsible, as Barnum and Mallard (1989) add, for the outcomes achieved by groups of organized care deliverers by managing the work of others. However, the ranks of middle management have been greatly reduced in hospitals over the past five years. Strausen (1989) estimates that one-third of all middle management jobs have been eliminated in the United States in the past few years, and finds that the remaining middle managers are in jobs that are challenging and interesting, but also demanding.

A strong argument is built by Dunne et al. (1988) that middle managers need more sophisticated knowledge and skills to assume a broader scope of problem solving and decision making responsibiities. After examining current position descriptions of middle managers, these researchers found that management practice had become more complex than before. Accordingly, they designed a program for the ongoing development of such managers which emphasizes, as the most important areas, management strategies, resource management, people management, and professional network development.

Essential skills for nurse managers were outlined by Vance and Wolf (1986), who surveyed the literature on this issue and then asked nurse leaders' opinions regarding skill areas required by contemporary nurse managers. The fifteen skills they included in their findings, in rank order, are these: fiscal management; communication skills; diagnosing and/or solving staff problems; decision making approaches; conflict management; leadership skills; using power, influence, and authority effectively; evaluation methods; management approaches and functions; building cohesive work groups; political dimensions of organizations and work groups; managing change;

motivational strategies; organizational models for nursing; and professional development of nurse managers.

On the issue of the transformation of nursing relationships and the redesign of roles within hospitals, there is not much literature at this time. However, one report on redesign (Ponte & Capodilupo, 1992) found that the supervisory role moved from a single service area to coverage of multiservice areas and became a role of consultation and direction on administrative issues only. It also found that as larger and more diverse areas became their responsibility, supervisors had more difficulty maintaining their own clinical expertise and the development of senior unit clinicians and clinical teachers became more of an issue. Ponte and Capodilupo (1992) write about change in the supervisory role from the "all knowing, ever present" nursing supervisor who corrects or supplements the individual clinician's practice to one who enriches the practice environment within the fiscal potential.

In another report, Gardner and Gardner (1992) examined the transition from clinical practitioner to institutional administrator and outlined the reordering of value priorities and cultural attitudes within that context. They point out that meaning and satisfaction no longer come from direct patient contact, but rather from team building skills and networking with colleagues. Capacity for dealing with conflict, risk, finance, information services, political systems, business, and managerial skills increases over time.

Overall, then, studies of the mid level manager role are limited in number, possibly because changes occurring in health care reform are recent and ongoing. They are limited in applicability to the role being examined here as well, since, as will shown later, decentralized organizational culture

has resulted in changing relationships and altered service boundaries and expectations at the hospital in question. For the same reason, studies of the first line manager role based on traditional functions of planning, organizing, direction and control are of limited usefulness here too. However, a replacement for the traditional dogma for such roles is offered by Senge (1990), who suggests that a "vision, values and mental model" would be better used to describe the work of the new leader today.

The Nurse Manager Role

Published work about redesign of an effective nurse manager role has become more apparent in the past three years (see Lima & Archer, 1994; Horvath, Secatore, Alpert, Costa, Powers, Stengrevics, & Aroian, 1994; Beyers, 1994; Everson-Bates & Fosbinder, 1994 as examples). Horvath et al. advise that data based descriptions of what constitutes skilled performance and developmental learning are essential for this. The everyday realities of nurse managers capture their practices and pragmatic concerns, while conceptual frameworks from general management and organizational literature may not.

Horvath et al. also report an explanatory and descriptive study using a phenomenological approach in which nurse managers' accounts of their everyday practices were interpreted. Twenty-nine clinical nurse managers from one hospital in the United States were asked to write management incidents or clinical narratives. Small group interviews and observations were also used to gather data. Comparison and contrast of the data text clarified common practices of nurse managers and the recurring themes of their accounts. Findings revealed "compelling stories about preservice therapeutic nurse-patient/family relationships, negotiating interdisciplinary

and intradisciplinary relationships, resolving conflict, creating a learning environment, and expressing their needs for formal and experiential knowledge" (p. 41). The special importance of this study to the current research is the methodology. Because the group under study was composed of clinical managers, the day to day activities recorded differ from those recorded in this research, but the use of stories from day to day worklives is common to both.

The relation of healthcare reform to nursing management activity is discussed by Beyers (1995), who notes a shift in the managerial role from traditional planner and implementer to coach, expert facilitator, decision maker, and team player. Emphasizing that the scope of the managerial role is becoming broader, Beyers suggests the need for what she terms "virtual management", a role with fewer boundaries, more interaction, electronic support, increasing communication, and less traditional structure. These ideas are very similar to concepts espoused by the administration of the hospital studied in this research in its Management Statement (1994). As will be discussed in a later chapter, the issue of changing boundaries was raised by the nurse managers who participated in this study.

A qualitative study to determine the selection process of nurse managers was undertaken by Everson-Bates and Fosbinder (1994), based on the belief that hiring effective nurse managers is a key to success in health care institutions. While this study focussed on the role of the first line manager, the role described included responsibility for stategic planning, budgeting, practice standards, hiring and staff evaluation, and creating working relationships with other disciplines, which seems comparable to much of the

role of the middle manager addressed in this dissertation. Several recurring themes were identifed by Everson-Bates and Fosbinder: strong self concept; flexibility; optimism/enthusiasm; positive identification with nursing; and competencies relating to communication, leadership, problem solving, staff development and "getting the big picture" (p. 34). Communication for conflict resolution was considered critical for success. The "big picture" was identified as understanding the macro reform in health care and communicating changes to staff. Ability to "thrive on chaos" and a need for flexibility was deemed important, as inflexible managers reported feeling angry, resentful and overwhelmed and exhibited symptoms of stress and burnout. This study described competencies that could be used to guide interviews and suggested their importance and effectiveness will become known in time.

The preparation of nurse managers for the future is addressed by Sullivan et al. (1994). Nurse executives, they advise, need to develop programs to help nurse managers meet rapidly changing role expectations and prepare for new health care challenges. One such program discussed by these authors, and influenced by the systems thinking described by Senge (1991), was designed around communication, team building, supervision, decision making, problem solving and diversity. It also introduced a mentoring component to help managers complete work on unit projects. Program evaluation demonstrated statistically significant mean scores on six of the nine categories tested, with the managers showing improvement in the competency areas of clinical practice, planning and organizing, fiscal management, resource utilization, problem solving and decision making, and

communication. All are competency areas similar to those deemed important in the present study, so the content areas offered in this particular educational program are where its importance for this dissertation lies. Communication, team building and decision making are recurring themes (Beyers, 1991; Everson-Bates & Fosbinder, 1994).

Consensus on the nature of, or the competencies required by, the nurse manager's role is sometimes difficult to find, however, as pointed out by Carroll and Adams (1994). One survey, which sought responses to fourteen statements describing possible functions of a nurse manager position, found nurse managers, nurse executives and chief executives all shared the same perceptions about what activities comprise the current and future nurse manager role. Overall, though, a thorough literature review by these authors revealed inconsistent reporting of methods and results, threats to internal and external validity, and differences in design, instrumentation and sampling techniques.

Designs, they found, range from anecdotal single case studies to reports on functions and tasks, levels of management, surveys and ethnographic analysis. Instrumentation ranges from questionnaires to checklists of tasks and competencies and observation. Conceptual or theoretical bases for the research were rarely found. Therefore, much of the research on defining the nurse manager role in acute care hospitals over the last ten years is fraught with methodological problems.

Carroll and Adams (1994) conclude their review, therefore, by advising that blended models, integrating concepts from managment and nursing theory and empirically tested, will be needed to generate a knowledge base

for the practice of nursing administration. Generalizability will be increased by employing both quantitative and qualitative designs, and by using multiple study sites.

This reasoning seems sound. Reading of nursing management research makes it clear that consensus has not yet been reached on competencies required for various levels of management in organizations or about a framework or model for organizing managers' work. A description of the nature of nurse managers' work should help such a model to evolve.

One point on which there is some consensus in the literature, however, is that the transformation of the health care system requires the reduction of costs while improving the quality of care (Beyers, 1994; Wolf, Boland & Aukerman, 1994; Sovie, 1994). Wolf et al. have developed a transformational model for professional nursing practice with concepts applicable to leaders in any discipline of nursing. According to these authors, transformational leadership is an interactive relationship based on trust, which impacts positively on both leaders and followers by focusing on purpose, and by creating unity, wholeness and collective purpose (p. 39).

The matrix designed for this model includes dimensions for a high performance team leader. One is hardiness, which is defined as personality factors reflecting an individual perception of commitment, challenge, and control. Another is empowerment, which involves an awareness of one's own personal talents, power, and contribution to the organization's goals. A third is vision, which is the delineation of a possible and desirable future state. The organizational culture, or the values and beliefs of the organization where trust, caring, mutual respect, and enthusiasm are demonstrated is a further

dimension. And, finally, there must be operating systems, which are systems and methodologies used to accomplish goals.

The high performance team with such dimensions would have a strong commitment to both the profession and the organization, and would be able to create a synergistic environment that enhances educational change, involves futuristic ideas, continually evolves, and can be translated into a reality base. Such an organizational culture holds key values which staff are able to perpetuate, as well as operating systems that can be questioned while synergistic systems are created. Leaders of high performance teams find different ways to accord team members' energy flow, creativity and innovation with operating values and cultural norms.

Though it was implemented at only one hospital, the model developed by Wolf et al., seems to have relevance to some of the transitions occurring and the values evolving at the facility that was the setting for this research, bearing in mind the risk of generalizing from one instance of success. Moreover, in a similar discussion about work teams, Sovie (1994) identifies boundary interfaces as one of the most challenging aspects of the nurse manager role, emphasizing that collaboration is necessary between medical staff, hospital administration, other health personnel, supporting departments, and staff in order to achieve patient care objectives. Though this is not a research based publication, it does provide useful observations regarding the changing nurse manager role.

The Patient Care Manager Role

The patient care manager role as implemented at the acute care hospital that served as the setting for this research is a new, evolving role, as will be

discussed elsewhere in this dissertation. The terminology itself is new. No literature was located which referred to the "patient care manager." This only underlines the importance, however, of initiating or contributing to discussion on the patient care manager role by seeking insight into how its practitioners make sense of their workworld and interpret their role. Thus it provides a fundamental motivation for conducting this inquiry.

Even without an existing body of literature, however, it is both possible and worthwhile to gain some preliminary insight into the theoretical basis for this new role. Some assumptions about the management of the workplace in which patient care managers are expected to engage are reflected in a management statement developed by the the corporate team of the hospital in question in 1993:

> Management is principally about the coordination of action, in the spirit of continuous improvement and learning, and creating environments in which people are empowered. Defined in this way, management is Everyone's job. (Management Statement, 1993)

Some of the underlying philosophy was also revealed to me in discussions with senior administrators of the subject institution and during planning sessions I was invited to, and did, attend. One of the insights I gained in this way was that the role of patient care manager will become increasingly important in the provision of quality care while addressing fiscal restraint. These two themes often present a dichotomy in everyday activities. The examination of quality care and total quality management is pertinent here.

Quality Care and Total Quality Management

As the major concern in today's health care environment became one of controlling costs while enhancing the quality of care, attention has been directed toward better measures of patient outcomes. While nursing plays an important role in determining expected outcomes, all parts of a hospital system are involved also. Collaborative action of all health care providers is necessary. Quality assurance has been well known to nursing for many years as comparison of performance to pre-established criteria has been expected (Boulerice, 1994). Various methods have been developed over time to measure quality in nursing including such routines as narcotic counts and more elaborate methods such as audits, patient satisfaction scales and patient interviews. Other departments developed their own tools to measure the results of their work. Some organizations developed system-wide centralized programs for the measurements of outcomes.

> A total quality management (TQM) model is the most recent attempt to redefine quality as a system-wide effort to improve effectiveness and to meet customer needs. (Boulerice, 1994)

Lopresti and Whetstone (1993) elaborate on TQM saying it represents a system's approach to quality based on a set of principles and strives to improve the effectiveness of services and to reduce costs. It has become a management philosophy based on the premise of finding constant sources of improvement to enhance both internal and external customers while using resources wisely. The development of standards and corresponding quality indicators is required. The focus is on teamwork and customer satisfaction.

Boulerice (1994) identifies obligations on the part of the organization to meet current client needs and future needs as:

- providing effective educational programs to facilitate informed decisions about risks, benefits and services.
- facilitating more active participation in evaluating services.
- discovering which activities have the greatest impacts on outcome.
- organizing services around activities and processes that make a difference.

TQM, advocates employee empowerment in that program evaluation is everyone's responsibility, based on top down leadership, key organizational processes and constant assessment by employees. It is expected that the organization will demonstrate greater effectiveness of outcomes and increased customer satisfaction according to Wilson (1992). Operational reviews include processes and client satisfaction as well as clinical and professional dimensions through audits of risk management and other quality assurance methodologies (Wilson, 1992).

TQM then, offers a basic premise of a customer focus, teamwork and continuous improvement. Issues related to the implementation of TQM are addressed by Boulerice (1994) beginning with team problem solving. Staff may feel a strain of added responsibility and team work which add to an already heavy workload. Further, cross-functional teams are expected to resolve problems and therefore need education to broaden their knowledge of the workplace. Finally, although customer satisfaction is the focus of TQM, some customers may not be able to evaluate the quality of service provided. Therefore, there is a need to educate consumers about treatment modalities, and about how to assume responsibility and make rational decisions for their own care.

The Role of Research in Nursing Organization

Diekelmann (1986, 1989, 1990, 1991) has become the current seminal publisher in the area of narratology and of the diverse kinds of research nurses can be involved in to further and develop nursing knowledge and practice. The complexities of this profession demand a plurality of research methodologies, including those that promote understanding of both clinical nursing knowledge and the lived experiences of nurses, patients, and instructors, she writes (1986). The teaching of nurse teachers is influenced by their nursing practice, Diekelman adds (1990), going so far as to call for a revolution in curriculum based on personal experience, in which the voices of others are listened to in order to gain human connectedness to guide the practice, teaching and research of nursing. She (1990) also urges a critical examination of nursing practice, rather than doctrine, in nursing curricula, so that the relationship context of the practice becomes the ongoing act of learning.

MacLeod and Farrell (1994) also call for a curriculum reform movement in the preparation of graduate nurses aimed at producing graduates with new and different perspectives to function well in this rapidly changing health care environment. Advocating a practice driven approach to curricula, these authors devised a curriculum to let students into the world of the practicing nurse, an important feature of which was that nurses were encouraged to share their stories with the students. The reality of nursing practice was made a central theme. The practice of nursing became commonly understood between students and practicing nurses, using a phenomenological approach. MacLeod and Farrell (p. 213) declare these common understandings essential

to achieving the common goals of systematic change in nursing education and health care.

The use of stories by Diekelmann (1991) also speaks to the creation of caring communities in which expertise, thinking and practical knowledge are identified. Relating narratives is empowering, she argues, because it allows the articulation of similar experiences and encourages common understandings about the practice of nursing and teaching to emerge. Stories from educators, students and practicing nurses are scattered throughout Diekelmann's writings, which point out that the shared common practice, illustrated by a story, is best revealed in a specific context. Diekelmann also talks about the experience of knowing "the teachable moment" and the importance of teaching that to beginning instructors. She considers teachers to be learners too, which requires a shift in thinking from the traditional perspective of knowing the answers.

To emphasize her point that cognitive thinking and thought about content can be developed about nursing practice with stories from both teachers and students, Diekelmann (1993) boldly states that "narrative dialogue is the new pedagogy at the threshold of the 21st century" (p. 249). Other authors add to the call for stories too. Both Benner (1987), who illustrated expert nursing practice using stories, and Sandelowski (1994) laud story telling as a way to transmit knowledge. Similarly, Kefoot and Sarosi (1993) discuss the power of stories to transfer knowledge and values from one person to another, suggesting that nurse managers can use stories to share values with staff.

While a parallel can be drawn between the use of narrative in educating nurses about practice generally and in the transmission of knowledge about the practice of management, there is limited literature about the preparation of nurse managers with a narrative approach. Mark (1994) and Sullivan et al. (1994) discuss the need for management content in nurse preparation and offer suggestions for content based on research which asks questions of managers about their critical priorities in education needs. Both of those studies report time spent in direct patient care by nurse managers as about 25%, while 75% of their time is spent on administrative activities.

According to Mark, theoretical content should include organizational behavior and theory, human resource management, financial management, information and decision support systems, legal and ethical issues, and creative strategies for work design. An administrative practicum is strongly recommended. Sullivan et al. (1994) suggest similar content, including fiscal management, communication, team building, management of change, motivation strategies, and problem solving. A key difference in this scheme, however, is the proposal of a systems thinking conceptual framework based on the work of Senge, emphasizing seeing the whole, interconnectedness, and patterns (Sullivan et al., 1994, p. 34).

On the whole, though, there is only sparse use in the literature of theoretical frameworks for the education of nurse managers. Laschinger and Shamian (1994) note that few theoretical frameworks are available for nursing managers attempting to create empowering environments. Testing Kanter's theory of structural power in organizations in a nursing setting, these authors used a managerial self-efficacy scale to measure empowerment concepts held

by managers. The instruments included a managerial competency scale and a managerial self-efficacy questionnaire. A significant relationship was found between perceived job related empowerment and managerial self efficacy and sources of power were seen to be: opportunity, information, support, and supply. Kanter's model of organizational empowerment was considered to have potential for nurse administrators concerned with empowering work environments. These results add to a growing body of knowledge about the nature of power in work environments and the framework deserves further investigation.

Summary

This chapter has examined the literature on the historical background and theoretical foundations of the management roles of nurses in Canada, as well as emerging ideas on the practice of nurses currently in such roles. One important point that can be distilled from the literature is that nurse manager roles are evolving, or being redesigned, in ways that distinguish them from traditional roles. Both the expectations for and the preparation needed by nurse managers are changing rapidly, resulting in a variety of suggestions about the education such roles demand.

There is not yet a clear concensus, however, about the nature of the work involved in nursing management or about the competencies needed to assume such roles. There is not yet even much consistency in research methodology in this field, in design, instrumentation, or analysis in studies on these issues. Conceptual bases are rarely found. Both qualitative and quantitative designs of various kinds are recommended to generate a larger knowledge base from which further discussion could grow.

If agreement on anything can be discerned in the literature, however, it is on the point that teaching of nursing management should be based in nursing practice. A practice driven curriculum would produce nurse managers with new perspectives appropriate to the rapid changes currently occurring in the health care world.

CHAPTER 3

Methodology

Methods utilized by nurse researchers to study problems of interest in the development of a scientific basis for nursing are diverse (Polit & Hungler, 1993). This diversity is considered critical to the spirit of science (Polit & Hungler, 1993), the aim of which is the discovery of knowledge. There is a rich variety of ways in which additions to bodies of knowledge can be approached.

Qualitative Research

One such alternative approach is qualitative research which seeks to understand human experience in a manner consistent with or especially attuned to the scientific and artistic nature of nursing (Lobiondo-Wood & Haber, 1994). It involves the systematic collection and analysis of more subjective narrative materials, using procedures in which there tends to be a minimum of researcher imposed control (Polit & Hungler, 1993). Emphasis is on the dynamic and holistic aspects of human experience in a particular context (Burns & Grove, 1995).

It is, however, often referred to as a soft science (Polit & Hungler, 1993; Burns & Grove, 1995; Morse, 1994) because methods of analysis have not always been well explained. As these researchers point out, knowledge about human beings is not possible without describing human experience as it is lived and defined by the actors themselves. The emphasis in this kind of

research is on the subjects' reality with the researcher trying to comprehend those persons whose experience is under study.

Qualitative approaches embrace the wholeness of humans, focusing on human experience in naturalistic settings (Lobiondo-Wood & Haber, 1994) in the belief that unique humans attribute meaning to their experiences and that experiences evolve from a life context. Naturalistic refers to the idea that the researcher imposes no constraints or controls to the setting (Polit & Hungler, 1993), while the holistic nature of qualitative research refers to the concern with the complexities of humans and their environment. Truth, in this kind of research, is believed to be the subjective expression of reality as perceived by the participant and shared with the researcher (Lobiondo-Wood & Haber, 1994). Truth is context laden. Imposing structure, that is, deciding in advance what questions to ask, would restrict the portion of the subject's experience that would be revealed (Polit & Hungler, 1993).

Factors considered in a qualitative approach are outlined by Polit & Hungler (1993) as follows:

- there is an attempt to understand the entirety of some phenomenon rather than focusing on specific concepts;
- the researcher has few preconceived ideas and stresses the importance of people's interpretations of events and circumstances rather than the researcher's interpretation;
- information is collected without formal, structured instruments;
- the researcher does not attempt to control the context of the research, rather attempts to capture that context in its entirety;

- there is an attempt to capitalize on the subjective as a means for understanding and interpreting human experiences;
- narrative information is analyzed in an organized but intuitive fashion.

Criteria for judging this kind of study have been outlined by Guba and Lincoln (1981) and supported by Sandelowski (1986) as credibility, that is, the truth of findings as judged by the participants and others within the discipline; auditability or accountability, which refers to the adequacy of information presented so the reader can clearly follow the study; fittingness, or the faithfulness of the researcher to the everyday reality of the participants; and conformability, which suggests the findings reflect implementation of credibility, auditability and fittingness. The rigor of qualitative methodology is judged by the unique criteria appropriate to the research approach (Lobiondo-Wood & Haber, 1994).

Morse (1994) cautions that the process of data analysis is poorly described in qualitative research. She says the audit trail as described by Lincoln & Guba (1985) has been one of the few guides for analysis. This inability or neglect of qualitative researchers to make explicit the cognitive struggle of model construction, according to Morse, has led to the belief that qualitative research is subjective and easy. Morse (1994) goes on to discuss the cognitive processes used in developing theory from data, which are described as comprehending, synthesizing, theorizing and recontextualizing.

Comprehending relates to the setting where, upon entry, Morse says everything about that setting and the experiences of the participants must be learned. The experience is viewed from the participants' perspective and

trust of the participants is vital. They must be willing to share information. Comprehension is reached when the researcher has enough data to write a complete, detailed, coherent and rich description (Morse, 1994, p. 27).

Synthesizing refers to the merging of several stories or experiences to describe a composite pattern of behavior, according to Morse. The ability to provide specific stories to illustrate a generalization is part of synthesizing, while theorizing is the sorting phase of analysis. Morse describes theorizing as constructing alternative explanations; speculating, selecting, revising and discarding. This is a way of revealing the obvious, implicit or unrecognized, as well as of developing patterns which are then verified or refuted by the participants.

Recontextualizing is the cognitive process which involves the development of theory so that it is applicable to other settings. Such theory can be generalized and recontextualized into different settings. The work of other researchers plays a critical role here, says Morse, because the researcher's model may link new findings to already established knowledge.

Narrative inquiry is the qualitative method with a unique perspective used in this research. It utilizes the four cognitive processes described by Morse (1994) at the descriptive level. Comprehending comes from interviews, observations and field study. Synthesizing links participant's stories into a pattern. Theorizing occurs, to some extent in the writing, the rewriting and the description. Recontextualization occurs as others recognize their lived experience in the stories and choose to look at their own nursing practice in other settings, in a different way.

Narrative Inquiry

Narrative inquiry as a method fits into the matrix of qualitative research because it focuses on human experience or the way humans experience the world (Connelly & Clandinin, 1990); it is descriptive and explanatory (Polkinghorne, 1988) and it contributes to the mission of nursing inquiry which is the understanding of living in health, illness and transitions (Sandelowski, 1991). Life's narratives are the context for making meaning out of learning situations (Connelly & Clandinin, 1990). Stories can articulate nursing practice (Morath & Mantley, 1993) and descriptive narratives can reveal how participants explain their situations (Sandelowski, 1991). In this way, insight is gained, lives are better understood, nursing practice (management) can be revealed and the opportunity for special access to a human experience is provided.

Clandinin and Connelly (1994) describe the basic premise underlying narrative inquiry as the storied lives people live. People by nature lead storied lives and tell stories about those lives. Narrative researchers describe those lives, collect and tell stories about them, and write narratives of the experience (Connelly & Clandinin, 1990). The experience of living in some context is shared by story. Eisner (1991) explains that stories are a way to tell about our experiences and to help others understand them. Polkinghorne (1988) suggests that narrative is a form of making meaning out of the focus of experience as it is lived, experienced and interpreted.

Other methods of qualitative research were considered in order to provide a description of the lived experience of the patient care manager. Grounded theory which sets out a systematic set of procedures to arrive at

theory about basic social processes (LoBiondo-Wood & Haber, 1994) is one possibility. The phenomenological method is a process for learning and constructing the meaning of human experience through intensive dialogue with persons who are living the experience (LoBiondo-Wood & Haber, 1994). That method also might have been utilized. However, narrative inquiry was chosen because of its underlying premise that people by nature live storied lives. Sharing their meaning of work in this particular context by sharing their stories seemed compelling. It is the goal of this work to have others understand these stories and, thereby, better understand the work of nurse managers.

Methodology of Narrative Inquiry

Structuring the Narrative

The structure of the narrative consists of time (temporality), place, scene and plot as reference points (Connelly & Clandinin, 1990; Clandinin & Connelly, 1994), elements which work together to create the experiential quality of the narrative (Connelly & Clandinin, 1990).

Ricoeur (1980) says time in the narrative sense is not considered the ordinary representation of time as a linear series. Rather, temporality considers the plural unity of future, past and present (p. 171) and is a within-time-ness, which is not reducible to the representation of linear time. In this sense, time involves the natural environment, the time to do something from day to day. Articulation of that day to day involvement interprets itself to what is called time.

Scene or place is where the action occurs, characters are formed and live out their stories (Connelly & Clandinin, 1990). Character and physical environment work in harmony with context, all three of which require description.

Plot has a beginning, middle and end, and is tied together to form time (Connelly & Clandinin, 1990) and is the intelligible whole that governs a succession of events in any story (Ricoeur, 1980). A story, Ricoeur says, is made out of events and plot makes events into a story. Plot places one at the crossing point of temporality and narrativity (p. 171). A story describes a series of actions or experiences made by characters in situations. As the characters react, hidden aspects of the situation are revealed, and the story is advanced to a conclusion by the thinking and action required. So a succession of actions, thoughts and feelings move the reader to expectations of outcomes. But a narrative conclusion can neither be deduced or predicted, Ricoeur writes, because intentions are based on a thousand contingencies. The conclusion may be acceptable, but not predictable.

Time and place, scene and plot work together to create the experiential quality of narrative (Connelly & Clandinin, 1990) and make the quality of subject matter the central value of narrative inquiry . The capacity of this kind of research to make life experiences relevant and meaningful is its principal attraction.

To begin the story of inquiry into the experiences of another, the researcher enters the field of study and records field texts (Connelly & Clandinin, 1994), which are compilations of observations, interviews and journal entries created by both the participants and the researcher to

represent aspects of field experience. These field texts are then moved into research texts where the restoring quality of the narrative takes form (Connelly & Clandinin, 1990). Present and future considerations are determined in relation to the meaning of the event under study. Listening to and writing about the stories of those experiencing a phenomenon should help in understanding a practice discipline and may generate new thoughts about theory-practice relationships.

Analyzing the Field Text

Riessman (1993) begins a discussion about narrative analysis by stating that the story metaphor emphasizes that we create order and construct texts in particular contexts (p. 1). The investigation of the story itself is the object of narrative analysis. The informant's story is examined to learn how it is put together and what it means to the listener. There is no one way to study narrative because of subjectivity. Each narrative is rooted in time, place, and personal experience.

Therefore, observations are collected, a selection of the totality of experiences is described and reality is constructed in new ways. The writer accounts in narrative personal experience to capture the moment. As communication about that experience is related, the meaning shifts since this is a representation of the process of interaction. That is, decisions about what and how to transcribe the experience make it of necessity an interpretive practice. The challenge, says Riessman (1993), is to identify similarities across the moments into an aggregate, a summation. Decisions about form, ordering, and style of presentation are necessary in order to create a metastory about what happened.

Evaluating the Narrative

Collaboration is inevitable because readers interpret text just as the writer and the participants have done. Truths about the experience are related to the context of the situation. Meaning is fluid and contextual (Riessman, 1993), not fixed and universal. How the experience is endowed with meaning is important (Sandelowski et al., 1989), rather than any final truth. Alternative truths (Riessman) aim for believability rather than certainty, and for enlargement of understanding rather than control. Generalizability is limited to the reader, therefore, and to his or her alternative interpretation of the narrative.

Enhancement of Rigor

Rigor, according to Sandelowski, is built into the design by using more than one source of data, and by continuous member checks with the participants. Member checks of the participants' realities are discussed further by Lincoln and Guba (1985) and Hoffart (1991) as an aid to the credibility of the research. The narratives are returned to those participants for verification that the descriptions capture the essence of their lived experience.

Transferability (Lincoln & Guba, 1985) refers to similarities from one context to another, that is, from the context of the study to the areas of desired application. The intent of the narrative is to have other readers connect with it by recognizing particulars, and by imagining and reconstructing the scenes for them from remembered associations with similar particulars (Connelly & Clandinin, 1990). A further intent may be that the research will contribute to improvement of the practice area (Eisner, 1991).

Validation is a process through which one makes claims to trustworthiness of one's interpretations (Riessman, 1993). Persuasiveness occurs when evidence from the informant's accounts seem plausible to the reader. The interpretation sounds reasonable and convincing. The audience is invited or compelled to feel stimulated or delighted (Riessman, 1993, p. 66). Correspondence is another way to show validity according to Reissman who describes this as taking results back to the participants. Lincoln and Guba (1985) called this method member checks. The participants read the reconstructed text and validate or confirm the meanings. Finally, coherence is discussed as a method of validation by Riessman. Coherence is said to be "thick" (p. 67) if it is global, that is developing an account which relates to the overall goal of the narrator; and thermal, where parts of the interview text about particular themes are repeated and therefore unify the text.

Narrative Inquiry and the Lived Experience of the Patient Care Manager

The illumination of the lived experience of four patient care managers in one acute care hospital is the goal of this dissertation. The stories of their day to day activities in their own voices will be recreated into a research text. Sharing the narratives with interested readers will help readers better understand the reality and the experience of managerial work. The method utilized to achieve this goal, that is narrative inquiry, was chosen to bring insight into the practice of these patient care managers by concentrating attention on their lived experience. Polkinghorne (1988) suggests that this kind of study focuses on experience as it is lived, experienced, and interpreted, elaborating that narrative is a form of "making meaning," as it

makes individual events comprehensible by identifying the whole to which they contribute.

The model for this narrative of inquiry is derived from the work of Connelly and Clandinin (1990) who offer three components in the process. Beginning the story, the first component, is the negotiation into the field of study. In this model, the negotiation is seen as a shared narrative unit. This is collaborative research and a relationship between researcher and participants is important. A valuing of each other establishes a collaborative relationship in which both researcher and participant have voice. It is important here (Connelly & Clandinin, 1990) that the researcher first listen to the practitioners (participant's) story, and that the practitioner first tell his/her story (p. 4). Time and space is given for the telling of the story.

The second component, living the story, is the continuing process of narrative inquiry which proceeds on several levels. People both live their stories in an ongoing experiential text and tell their stories in words as they reflect and explain themselves. The narrative becomes complex here, because the researcher is seeing and describing story in the everyday actions of the participant while simultaneously becoming part of the process. The narratives of both the researcher and the participants come together as the story is shared, reconstructed and interpreted. An understanding of parallel experiences and a unity of patterns becomes the goal. During this phase, several narrative data sources can be utilized. Field notes through participant observation is a primary tool. Journal entries, interviews, story telling, and conversations are others.

The final component of this narrative inquiry model is that of writing the narrative, which in fact begins in the early negotiations with the participants (Connelley & Clandinin, 1990) and continues throughout all phases. Field notes and interviews provide data for building into a research text from which the narrative is constructed, analyzed and recorded.

In this study, PCM is used as a shortened version of patient care manger. A "Unit" of care is the grouping together of fifteen to twenty patient beds. Each specialty (e.g., surgery, medicine, pediatrics) is grouped according to the medical diagnosis. An "area" of responsibility would involve several units in the same specialty.

Beginning the Story: Negotiations into the Field of Study

A month of field work in May 1994, aimed at gaining a general overview of the role of patient care managers at this hospital was arranged between the Department of Educational Administration, University of Alberta, and one vice president at the hospital. This vice president acted as a mentor and an administrative contact for me during both that first month and the months of continuing study that followed. An office was arranged for me so that I was close to administrative offices, and this mentor was available for short consultations frequently. She also introduced me to patient care managers, arranged for my meeting with key personnel, and suggested activities which would enhance my learning.

I initially met with patient care managers as a group during one of their regular meetings and was given a few minutes to introduce myself. I told them I was a graduate student currently in the hospital to look at the patient care manager role, and that I hoped to research that role in some

manner in order to complete a dissertation for an EdD degree. They were given an opportunity for questions and were then asked if any were willing to do interviews and be observed at their day-to-day work. Most agreed. Some readily volunteered to see me, starting the next day. Coincidental to my study related to their work, these managers were working to redefine their own role because of transitions taking place in their work. It was subsequently agreed that I would help with that role redefinition to which end I spearheaded a one day workshop at the end of the month to design a description for their role. I was to build on the work they had done to date, the result of which can be seen in Appendix I.

Over the course of the next three weeks, I interviewed twelve patient care managers regarding their current work and their feelings about transitions in the role. At the end of each interview, I mentioned my own research and asked if they would be interested in further indepth interviews and observation. At the same time as I was conducting these interviews, I was sitting in with the vice president at a number of administrative meetings relating to changes in hospital structure and health care reform, which provided a good picture of the overall hospital functioning and the way in which patient care managers would be utilized in future restructuring.

Several volunteers offered to participate in my study. Since I planned to use narrative inquiry as a methodology, and because I expected to gather a great deal of data, I wanted a small number of participants. The broad interviews with the twelve managers helped me to determine the participants I would choose. Selections were based on a cross section of patient care managers and specialties to provide varied representation from nursing areas

so I could look for commonalities and differences in their stories. Selections were also based on high interest in the project, ability to articulate their roles, changes in these roles, and willingness to share views on the role changes, feelings about their work, and stories about their lived experiences. Arrangements were made for my spending an indefinite amount of time with each of those selected in an observational role once the proposal was accepted by all involved.

Following that month of field work, time was spent completing the proposal, gaining ethics approval, and gaining approval from the research committee at the hospital. (See Figure 1.)

Participants

Four participants were ultimately chosen, one each from the medicine nursing care group, the surgical care group, the pediatric care group, and one currently working on special projects. Each unit of patient care consists of approximately 16 patients. Each pcm was responsible for several units of patient care in various specialty areas. Each pcm was willing to share day to day work experiences by having me shadow her for a period of time, and agreeable to frequent interviews. All shared the view that it would be important to illuminate her management practice for colleagues doing similar work.

A brief introduction to these four participants follows. Pseudonyms are used in each case to protect anonymity. Confidentiality was carefully guarded and an attempt has been made to use terminology which will not readily identify areas of work. Because a great deal of the work of each patient care manager is by nature confidential, some of the stories elicited

Figure 1

Time Line for Narrative Inquiry: The Lived Experience of Patient Care Managers

February 1994	Beginning the story Negotiation for entry into context Observations, interviews Selection of four participants
March/April 1994	Writing proposals Ethics approval Setting approval
June/July 1994	Living the story Observations, field study of four participants
August/September 1994	Transcriptions of all tapes Validation, member checks of field text
October 1994 - January 1995	Writing the narrative Library research Writing text Validation with participants
February/June 1995	Writing
June 1995	Contract time with agency completed
July - December 1995	Writing, reconstructing
January 1996 - June 1996	Rewriting

cannot be told in this report. Although that may be a loss to some readers, it should not detract from the overall illumination of the role.

Linda

Linda is responsible for several nursing units in one nursing specialty. Her past nursing experience includes work in small rural hospitals and large acute care hospitals in other cities. She moved to this hospital as a patient care manager five years ago, beginning as manager of one nursing unit. As changes occurred, she accepted responsibility for more and more units.

Jackie

Jackie is responsible for six areas of nursing, all similar in the kind of patient admitted, although a wide variety of care is provided. She has been a manager in this hospital for several years, but has recently been moved to this particular specialty area.

Kate

Kate was recruited to work in this hospital four years ago, because of her specific expertise in this particular specialty field. She also has extensive experience from other hospitals. Kate is responsible for five areas, plus satellite areas in surrounding communities.

Anne Marie

Anne Marie came to this hospital from out of country some fourteen years ago. She began work as a general duty staff member and accepted positions in management as they became available. She has been a head nurse, a patient care manager, and acting director. At the time of this study, Anne Marie had been moved from a specific management position to a special projects position, working on committees related to the transitions

taking place in the hospital. She agreed to participate in the study and brought a wealth of information because of the various positions she had held.

The Process

Inquiry was conducted here by following (or shadowing) four patient care managers as they went about their day to day activities over a period of two months. Each was interviewed many times, sometimes at the end of each day, sometimes during the day, and sometimes on days other than the "shadowing" time. Each interview was taped, transcribed and reviewed for content. The transcripts were used to look for commonalities and determine themes. Field notes were made of my observations each day while I was with each participant and became an important part of the research data base. The field notes and interviews were reconstructed into a research text. Major issues and themes were identified. As the narratives took form, and became shaped into themes, the work was taken back to the participants for validation. They were asked to confirm that what was written was indeed what had occurred, or what they had said.

Validation of the work took several forms. Group meetings were held to discuss the overall nature of the study. These worked well, except that it was difficult to have all four present at one time. Also, during the course of the study, one of the participants left her position at the hospital. Individual meetings were then held with each participant. Some minor changes were made based on their review of the written work. Generally, this was a smooth process with all agreeing that the written work represented what had occurred. The succeeding chapters discuss the results of the observations and

interviews with these four participants. Themes with supporting stories are presented.

The writing of the narrative has been a long and detailed process. Following the time spent in the field of study, I had to return to full time work, in a career that is busy and challenging. It became more and more difficult to find enough hours to complete the analysis of the narratives and to reconstruct the narratives into a meaningful whole. For me personally, that writing will not be complete even at the end of this dissertation. The power of this method of research has moved me to want to continue asking nurses to share their stories, to examine their narratives and recreate their practice.

Ethical Considerations

Eisner (1991) provides considerable discussion of the need for "complex appreciation" (p. 28) of ethical considerations in qualitative research, emphasizing that there is no one set of rules. He suggests that, because the researcher cannot always inform participants about the exact course of the research, consent is not wholly informed. Because the researcher is interested in the context of the environment in which the study is being carried out, privacy and confidentiality cannot always be guaranteed. The ideal may not be attainable, but use of sensibility, taste, and rational judgement enhance the ethical position (Eisner, 1991). In this research, these limitations were discussed with, and understood and accepted by, the participants.

Punch (1994) would support Eisner's position, elaborating that the need to protect subjects versus freedom to conduct field work presents a dilemma. Concern revolves around issues of harm, consent, deception,

privacy, and confidentiality of data (p. 89). Emphasis on trust, identification, empathy, and non-exploitive relationships ensures ethical relationships between the researcher and participant, inhibits deception and helps to counter concerns. Cooperation and collaboration representing personal commitment to an ethical standpoint is the aim of such inquiry. Since participants are seen as partners in the research process (Punch, 1994), deception of any kind would undermine the very processes to be examined.

Summary

This study, then, strives to illuminate the work of patient care managers at one hospital during one period of time. Like a snapshot, it provides readers a picture of the lived experiences of four patient care managers. It is hoped that this description of the practice of management in one acute care hospital will aid readers in a broader understanding of management practice as a whole.

CHAPTER 4

The Lived Experience

One of the challenges with conducting research through the process of narrative inquiry is that the data collected can be copious, diverse, and unwieldy to organize and report. This is so for two reasons. A free flow of communication must be encouraged between participants and the researcher to elicit genuine and thorough recounting of experience. And researchers must be careful to keep the process as free as possible from their own biases in the selection of what is observed, asked, recorded, reported, and discussed. All stories, anecdotes, remarks, and observations must be treated as results.

Such was the case here. Despite a small sample, too much was related by the participant managers and observed by the researcher to be presented and discussed here. Decisions on inclusion and omission of material had to be made. Accordingly, priority was given to issues which seemed to be of the greatest significance and were raised the most often. Certain commonalities in the experiences of the PCMs were evident almost from the outset of the field experience and remained so throughout the investigation. Those commonalties are identified and discussed here using a model of narrative inquiry.

Beginning the Story

For me, entering a hospital is like coming home. I know the sights, sounds and smells well. I feel as though I did much of my growing up during the time I did my early education in a hospital. A large part of my life since

has been spent working in hospitals. So when I'm in one, when I walk the corridors and note the action, the cacophony is familiar. A feeling of comfort surrounds me. So it is as I enter this particular hospital with permission to conduct research about patient care managers. But I'm excited too.

I look around. This world class institution has been built in a circular fashion with an outer ring which houses medical services. Food kiosks are numerous in the centre. A cafeteria, gift shop, post office, lottery booth and bookstore are located around the periphery of the first floor. Visitors and patients mingle in this area from early morning to late into the night. Medical personnel hurry by. A paging system calls out names and locations. Supplies are delivered. Floors are cleaned. Remove the wheelchairs and intravenous infusions and this area could pass for a busy shopping mall.

A ride in a glass elevator up one or more floors, however, reveals a different environment with another focus. The setting is still pleasant. Open walkways lead from the elevators to the units. Patients drink coffee in open lounges. But the atmosphere has changed all the same. It is quieter, and more serious. Everyone walks faster here, many identifiable by uniforms, lab coats or name tags. The overhead intercom is almost always on. Doctors are paged. Codes are called. Nurses confer in halls. Relatives look tense. Order is required. The emphasis here is on reversing illness, on saving lives.

In the past, order in this and other hospitals derived from a traditional bureaucratic structure and hierarchy of command. Overall institutional function was the responsibility of a hospital board to which a president or chief executive officer reported and to whom managers farther down the organizational ladder reported in turn. Formal rules and structures for

operations were provided. Lines of communication were laid out in organizational charts. But the organizational structure changed. Figure 2 illustrates it as it was in the institution under study in 1990, while Figure 3 shows what it had become by 1993. Several key positions were eliminated.

One such of considerable importance to this research was the position of Vice President of Nursing. That position was replaced by three Vice Presidents, Patient Services. Three of those positions divided nursing services and included other service disciplines responsible for nursing in three broad clusters of medical service.

Figure 3 shows a conceptualization which seemed apparent to myself as researcher based on discussions with the participants. This conceptualization is specific to the activity of the patient care manager at the time of this study. It is intended to depict the responsibility and communication of the PCM to various disciplines now within her purview.

Experiences of PCM's During Transitions

Time spent with the participating patient care managers revealed to me that the transitions in organizational structure alluded to above are having great impact on their work lives.

> In 1992 when I started here, I was hired as the manager of one unit. I knew I could do the job. I had run a unit like that before. Similar size. Similar situation. One year later one other component [home program] was added to my workload. Four months later another portion was added. Finally all parts of this program were added. So within a year and a half I had the whole program. This is because of the changes taking place within the hospital. It has meant longer hours. I'm usually here before seven in the morning and most days I get home at 6:30 or 7:00 in the evening. That would be an early day for me. Lots of times it's 8:00 or 9:00 p.m. (Kate).

Figure 2

Organization Chart - Administration 1990

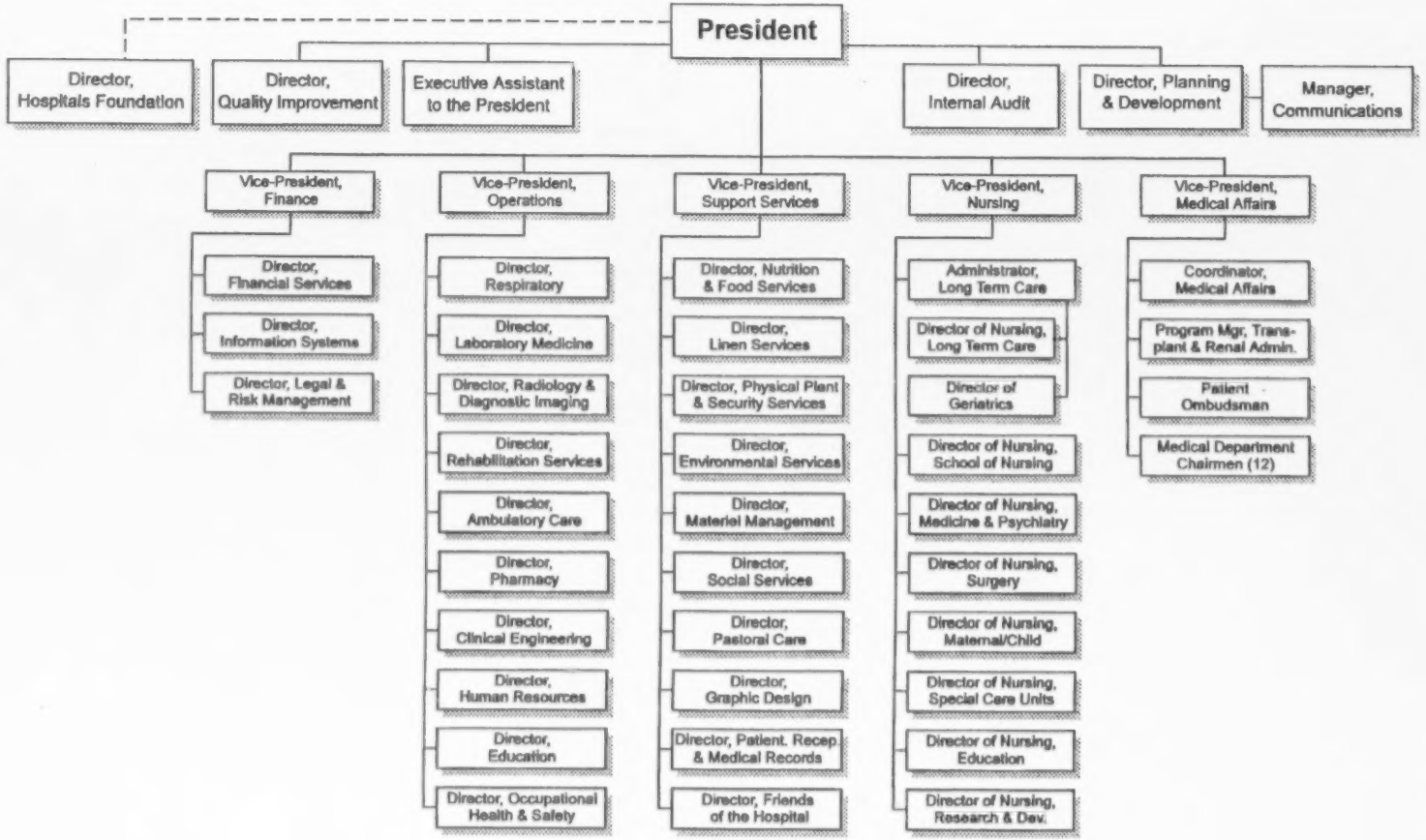


Figure 3

Organization Chart - Administration 1993

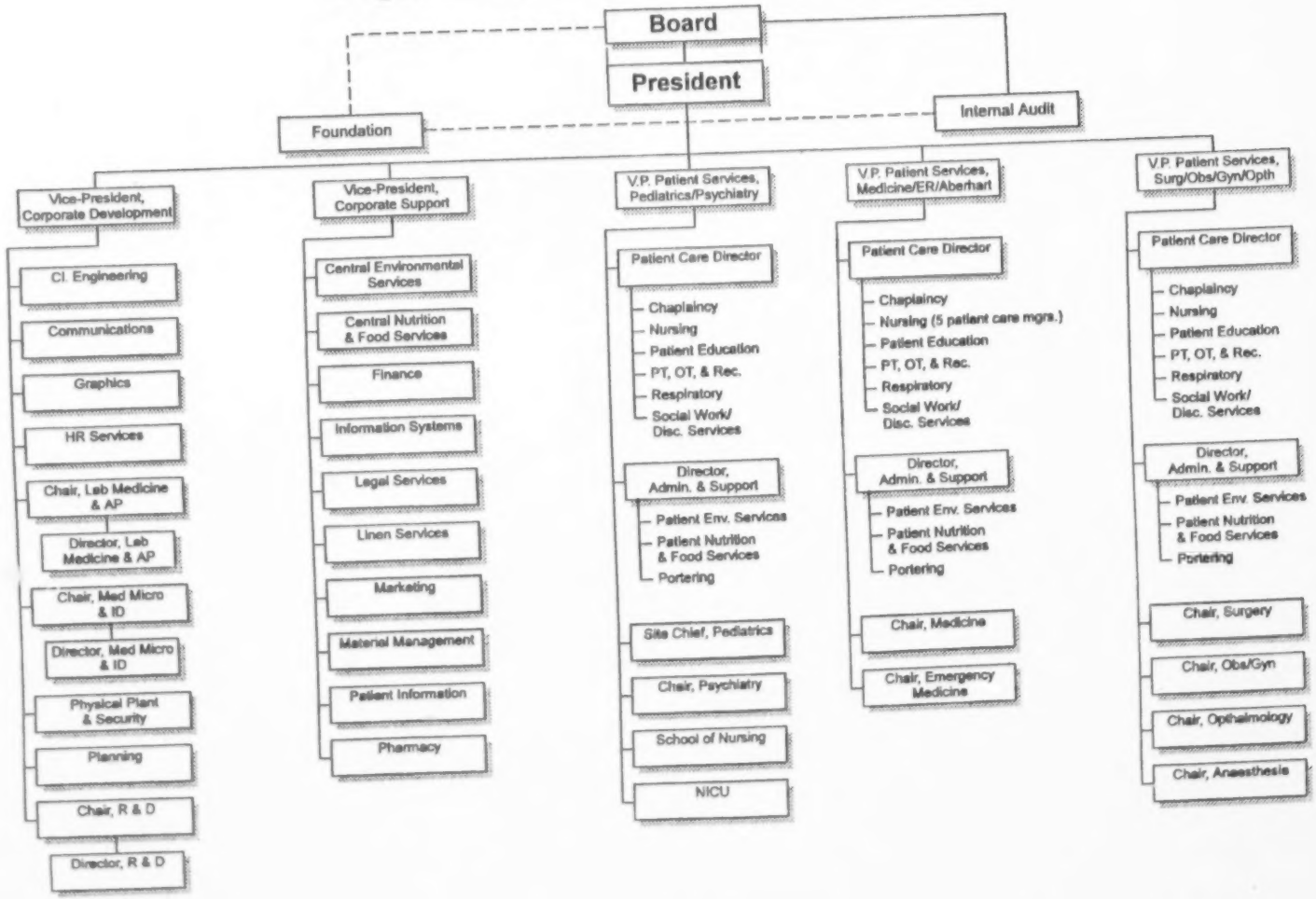
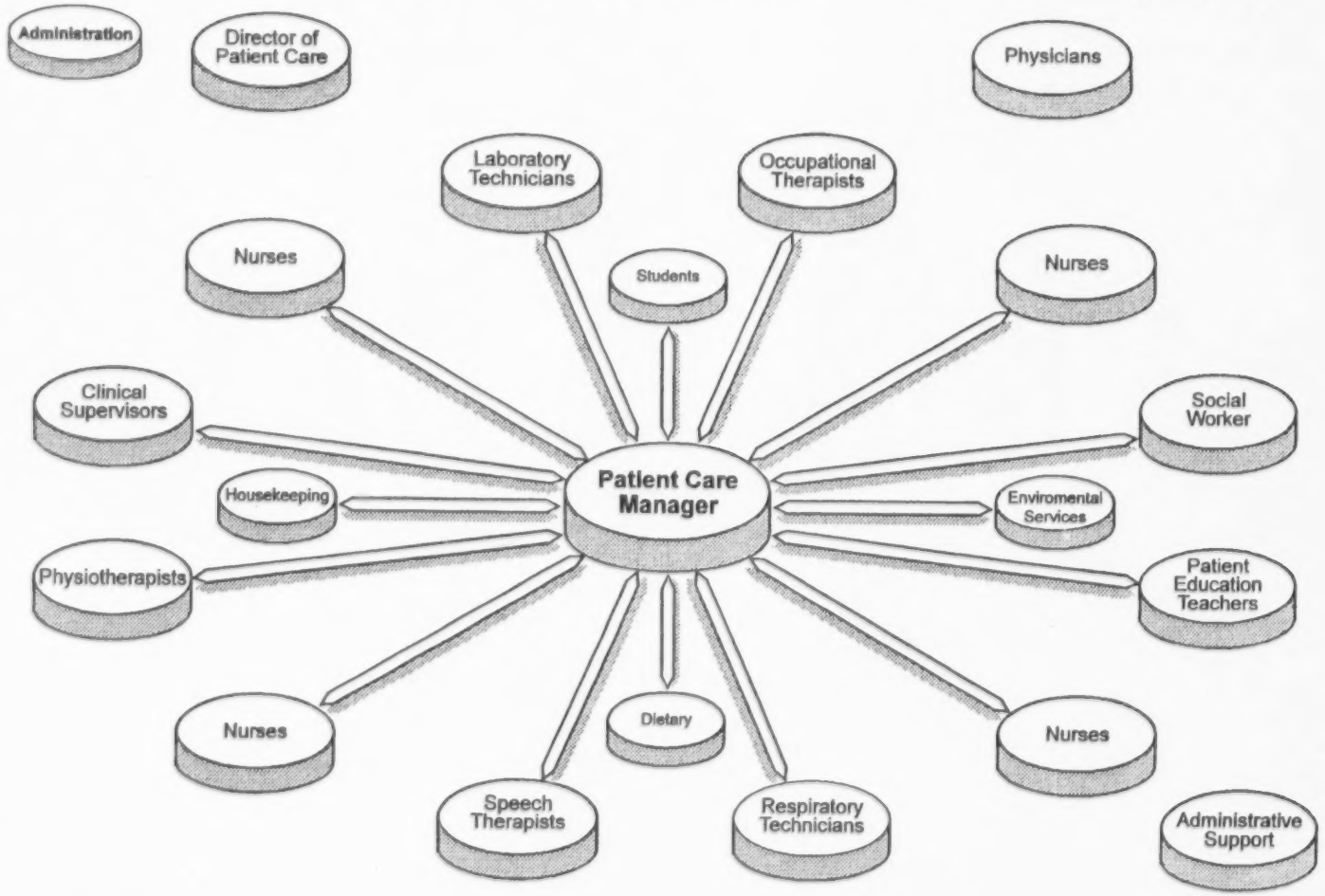


Figure 4

Apparent Organization Chart at the Level of Patient Care Manager 1994



> I took this job, really my first management job, and I've been here for five years. From a manager of one unit, I just kept accepting more and more units under my control. As the major changes occurred in this hospital, I had to learn new areas very quickly (Linda).

It is clear that the changes occurring in the hospital relate to reorganization of the structure, increasing the span of control of each patient care manager. Once responsible for a single nursing unit, they are now responsible for several, leaving them with more people to know, more nursing protocols to implement and maintain, and longer work hours. At the same time, efforts to reduce hospital costs have reduced or downsized the numbers of nursing staff available to them. As will be shown, this is one of the effects of organizational change that has the most impact on the patient care manager's current role. Gradually, as well as responsibility for more nursing units, they also became responsible for other departments. When the director of rehabilitation services, social services and environmental services were downsized, these areas became the responsibility of the patient care manager.

> Then with the layoffs that was, like I say, another major challenge in the job [that] seemed to unfortunately come more frequently... It's really threatening for the staff. And one of the hardest things the staff had to deal with, and we had to help them with, was trying to get them to stop talking about the situation on the floor, around the desk area, on the elevator (Anne Marie).

> I mean, you know we're human and people are worried about their jobs and their homes and everything else. I think, too, the longer you are the manager, the better you get to know the staff. And I think, too, over the years maybe it's becoming harder to go through the layoffs because you knew everybody's personal problems which came out in the wash, somehow or other, either through their behaviour or when you talked to them at evaluation time. I

> think that made it... It was quite draining. And very long hours... I know I used to be a hands on manager and walk away and let the staff run the place and I would always say to them... In the first few months, I was very much on the phone. I would let them phone me at 2:00 or 3:00 in the morning (this is when I started on the new unit) and they had lost the nursing office. They had lost the IV team. They had lost a lot of supports. And, in a way, a lot of the managers were becoming their nursing office (Anne Marie).

> The thing that saddens me a lot of the time, too, is that because of the union rules you lose your juniors all the time, who are your fresh blood, your enthusiastic young kids coming in, and getting left with some of the people who think "I'm okay for life and nobody can touch me so I can sit and..." You know, that was so frustrating because each time we did layoffs we were losing at least three or four from this ward, and two from this ward (Anne Marie).

A key issue for each of the participating patient care managers, as will be seen as a work day in the lives of each is described, is the maintenance of optimum patient care. "I'm committed to the overall process of providing good patient care," says Kate. The problem is how to do so with fewer staff. "The challenge is to continue to provide optimum patient care," Jackie maintains, adding, "By improving the work of the staff, I hope to have them improve their [patient] care." And Linda said, "anything to do with patient care is a priority."

Living the Story

Complexity and Pace

The first commonality to become apparent was the fast pace and great complexity of the environment in which the subjects live and work. Each patient care manager is expected by the terms of her employment to be responsible for the quality of care provided to each and every patient on her unit and for the coordination of all the systems, procedures, and resources

needed for routine, day-to-day operations to be maintained. To illustrate this, I have included excerpts from my field notes detailing a complete workday in the life of three of the PCMs, and an overview of the work of the fourth manager in the study.

A Day in the Life of Kate

> It's 7:30 a.m. as I enter the hospital and find the small office where Kate, the nurse manager I'm shadowing today, is already on the phone. She waves me in so I overhear her conversation. She is negotiating with a sales representative for a lower price for supplies, telling him she likes his products but her budget has been slashed and another company can beat his price. They agree to talk again when he's reviewed her figures. She hangs up, makes notes, then glances at me with a smile and tells me this is one she'll win. I thought I was early. Our appointment was for eight. Ahead is a meeting with the team, with one of the patients requiring multi input, especially from the nurses, she tells me. But she has already made rounds of the units and signed payroll cards for the week. Her day started at 6:45 a.m. The team in this case, is made up of the physician, residents and interns, nurses, social worker and Kate, with myself as an observer.
>
> Though pleasant banter precedes it, the meeting is serious and intense, with contributions from all team members and conflicting views arising, especially between doctors and nurses, about patient care. I make a note to ask Kate about that later. When the meeting ends, we remain in the room for yet another, involving general nursing staff only this time.
>
> One issue regards the difficulty of finding available nurses to accompany family members to the morgue when patients die. It is agreed that a body may be kept on the unit for two hours after death in the hope that families can arrive in that time. There also is discussion of patient teaching, of medications, problems with housekeeping (cleaning of rooms and changing beds isn't done fast enough for nurses, but the housekeeping staff blame the delay on the nurses for being "messy") and concerns about layoffs. And again there are calls for more staff. There are problems starting central I.V. lines, usually done by expert nurses, and more nurses are needed to complete doctors' orders, now being left until late in

the day. The comment is made, "We've run out of nurses and we've run out of time." Kate praises and encourages her staff, promises to keep them informed and undertakes to raise certain matters with administration.

Lunch consists of a sandwich and coffee in the cafeteria, greeting other PCMs and briefly discussing concerns with her immediate supervisor, the Director of Patient Care. Then we're off to yet another meeting, to acknowledge new additions to the staff this time. A cake is served. Kate welcomes each new member by name. A brief period of light chatter follows.

Then as we are leaving, a clinical supervisor taking early retirement asks Kate for a moment to discuss her replacement. Later Kate tells me how difficult this staff member will be to replace and relates some of her difficulties in bringing the team together. She stresses the importance of this sort of meeting in integrating people from the many divergent disciplines she has under her now.

On the way back to her office, Kate is stopped again, this time by a breathless nurse with news that a long term patient has walked into the President's office to complain about recent changes. Kate is needed at once! I do not witness her handling of this. But I do accompany her to the budget meeting of all patient care managers and administrative personnel that follows. It emerges that equipment and supplies have been decentralized but not enough sharing has developed between units. Teamwork, nursing workload, quality work improvement, and the organization of charts is discussed. A patient care questionnaire has been designed. Some issues are relegated to committees.

Then, about 4:00 p.m., we return to Kate's office where a nurse from out of town is waiting for advice on opening a new unit in the north. Much of the needed information is at Kate's fingertips. She promises to fax the rest.

At 4:45, on Kate's suggestion, I go home. But she stays. She has rounds of the units to make, voice mail to attend to, phone calls to answer and memos to write. As I leave, she reminds me of our meeting tomorrow, scheduled for first thing. She'll work tonight until 7:00 or 8:00.

A Day With Linda

When I arrive at 8:00 a.m., Linda is signing the payroll, a time consuming task of matching each staff member to hours worked the previous week that every patient care manager does each Monday morning. Usually on this unit people hustle by, the intercom blares and carts rattle back and forth. But it is quiet here so early in the day. Physicians stroll by chatting about patients or the weekend. One stops to speak with Linda about a patient needing specialized staff. She promises to get back to him on that.

We head for her small office, decorated with enlarged snapshots of patients and a framed certificate for "front-line management," when payroll is finished. This time slot has been set aside to tape an interview for my research, something there has been no time for so far in the three days I've already been here. As we begin, though, a supervisor stops in about plans for a new center that will be added to Linda's workload. Next the area educator arrives with news about the new ERIC and MEDLINE additions to her computer. Then the phone rings. A policy grievance has been received on an issue of downsizing and a meeting is being arranged to determine whether, when units are closed, staff should be laid off altogether and selectively rehired or merged and layoffs kept to a few.

Finally we're alone and Linda's free. She tells me about a decision she must make this morning about introducing a new piece of equipment, a new defibrillator, to the staff. The problem is everyone is busy. On the other hand, there is never a good time to explain something new. She runs through the pros and cons, decides to go ahead with it as she'd planned, leaves for the unit, and organizes the required session.

It's after lunch by the time we're back. But before we return to our plans, Linda must call the human resources department about a change in staff. She is worried about a member who is "bumping" in having made no contact. Then we head for another unit to see a part-time staff member about working extra hours. On the way, a "111" is called on the intercom. We both stop and listen…an automatic response…in case any of Linda's areas are involved, but they aren't, so we continue on. On the way back, Linda is stopped by the medical director over a question of summer staffing and the issue of safety in transfers of patients between hospitals. She makes a note.

Back at her office, she meets (in my absence) with a nurse who is unhappy with having been laid off, then phones the units we haven't had time to visit. She asks how each is doing, who worked when and who can be brought in, then reviews a list of layoffs for former staff who could be called back in per union rules. She dials. As she waits, she tells me that ten patients were transferred from another hospital to her units. They've been at peak capacity since. There is no answer. She dials again and again.

It's late now. I comment that not much of what has been done was on her calendar when the day began. She smiles. One must be flexible, she says. A clerk stops in about entering statistics on a new mini-computer that's on trial. Someone calls about a new blood gas routine. Someone else calls about days off. A part-time staff member comes in angry, wanting an overtime slip. After Linda helps her fill it out and praises her work, she leaves happier than when she arrived.

Suddenly it's quiet. It's 4:45 p.m. Finally we do a short interview on tape. Then Linda suggests I go home. She has a few things to attend to herself. Tomorrow she has a management focus workshop to attend. I ask her how long she'll work.

"Till it's done. Or I collapse. Whichever comes first," she answers with a shrug.

Jackie's Day

Jackie is also on the phone when I arrive, arranging a 12:30 p.m. meeting. Her small office has a window looking out to the hall. The blind is down. The hallway is noisy. People clean. Trays clang. Voices hum. Inside it's bright. Personal pictures abound. There's a large filing cabinet, a computer and the hospital mission posted on a bulletin board. There's barely room for another person to sit down. Work is stacked in "to do" piles. Nursing units and the T.V. room where families visit are just outside.

The first thing we do together is make rounds. And the first concern raised has to do with staffing. Some staff have called in sick. Others are away. An R.N. who has been on days off has taken charge. Only two are on evenings, so relief staff are needed ("strong people" only, please). One patient with a gunshot wound is on

constant care. The family of another is upset and wants to see a supervisor at once.

But Jackie moves through the unit calmly, quietly, and authoritatively. She advises the R.N. in charge how to manage with the staff they have and to review the policy on constant care for wounds of this type. She checks overtime sheets for possible staff replacements. And she meets with the agitated relatives. By the time she's done with them, they are settled quietly at the patient's side.

We pass on to a small office with two computers where two staff members are phoning for extra staff. Jackie thanks them for their efforts, reminds them that skilled, critical care staff are required, and listens to them vent their frustrations with the difficulty of keeping up with a constant demand for casual staff. Then, before leaving, she asks them to also locate a security guard for the patient on constant care.

As we move on again, we talk. Jackie misses the large centralized staffing office that used to have the responsibility, now hers, of finding extra or replacement staff on a daily basis. A staff member stops her with a request for certain days for vacation. Jackie makes a note. Then a supervisor complains about the environmental services team. Garbage removal and hallway cleanliness have fallen behind. A sign on the hallway wall has phone numbers for the Premier and the Minister of Health. When I ask if patients use them, Jackie shrugs.

At the next unit she discusses a Workers Compensation problem, individual care of each patient and the forms the clerk should use for inter-hospital patient transfer. But at another unit she faces staffing problems again. Several units have been merged. Staff preferences for when and where to work have not been met, disputes over seniority have arisen and grievances have been filed with the union.

Rounds are completed at 10 :30 a.m. at the busy clinic area. No urgent problems are evident there so far. Since a meeting has just been cancelled, we have a short break. Jackie takes a coffee back to her office to return phone calls. One is from a staff member wishing to move from full-time to part-time. Another is from the family of a patient who was billed for a private room after he died. Then occupational health and safety forms are brought in. Jackie places a

couple of calls of her own. One is to the hospital lawyer asking if the hospital is responsible for the loss of a patient's glasses and dentures. The other is to check whether a staff member who filed a Workers Compensation claim worked last night.

So on the morning goes. A financial analyst stops by to chat about a task force report on classifying donor patients and a new audit system on the computer to compare reliability of care between units. A draft of the disaster plan is delivered for Jackie's comments. Calls come in from staff whose work hours have been reduced. There is a meeting with other PCMs and the Director of Patient Care.

At 1:00 p.m., I mention hunger. Jackie agrees to stop for a sandwich. Over it, we discuss a research proposal for measuring patient, nurse, and physician satisfaction that Jackie and a small group have developed. Though not yet funded, it is topical, has attracted much interest, and will be presented at a conference next week.

Back in the office, one nurse drops by to ask for an appointment and another pokes her head in to ask if Jackie will be attending another staff member's baby shower tonight. It's important to team work, so she will. By this time, there are more phone calls to return. Then a research nurse comes in to discuss a study comparing two drugs. Jackie agrees to raise the question of participation in it with her staff.

At 2:00 p.m., there's yet another meeting which Jackie chairs. It's about summer relief staff this time. A critical care float pool is discussed. Required skills, staff expectations, and orientation come under consideration. It's obvious that staff levels will be low, but vacations must be taken. "We need flak jackets," Jackie tells me later.

A final meeting with other PCMs again follows. Its purpose is to re-examine alternatives to reducing costs through layoffs. The PCMs want a cap on the number of staff that can be bumped from one area, but the union won't agree. The high costs of orienting new staff is discussed. A "decision tree" is drawn up to help think through mergers and accompanying seniority issues. Low morale, grievances, and the effect on patients are considered. The need for relatively happy front-line staff is one thing on which all agree.

> By the time we return to Jackie's office, it's 5:00 p.m. She suggests I go home. Meanwhile there are the notes she made throughout the day to follow up on before she goes to the baby shower. There are thirteen messages on her voice mail too.

The Work of Anne Marie

Anne Marie occupied a number of different roles during the course of my research, none of which lent themselves to observing and reporting a complete working day as was done with the others. Accordingly, I relied more on interviews than observation in eliciting her views and in obtaining material from which to reconstruct the story of her work. For this reason, an overview of her work is provided here in her own words rather than in mine. When I first met Anne Marie, she was sitting in an office as a temporary Director of Patient Care, filling in during an absence. In a lilting tone and with a gentle sense of humour, she told me about her work life in the hospital, discussing at length the issue of expansion of the patient care manager role and the addition of other disciplines to her role. That gave me a new insight. While previous accounts focussed on the additional units of care patient care managers were taking on, Anne Marie's story drew my attention to the addition of other services and disciplines to the demands of the role.

> I've worked here for fourteen years in one capacity or another. I began as a nurse on the floor and, when the head nurse left, I was asked to fill in. It worked out okay. The role at that time [ten years ago] was so simple. You sat at the desk and processed orders and did rounds with the physicians. You knew all the patients and everything about them. That was the nice thing. The title changed over the next few years, but the role didn't really change. Things pretty well rolled on from '86 to '90, [head nurses] just having one unit and just daily routine work. I could come in at 7:00 a.m. and go home at 3:15 p.m. I had all senior staff and the unit had only eighteen beds.

Then, in 1988, there were ripples of change. Some people disappeared. Some changes [occurred], nothing major. So, in 1990 the role changed. That was when we were told that no longer would it be a head nurse on one unit. Suddenly it was either 36 or 54 beds. The role was now that of manager and that manager looked after between three and six units and became responsible for the budget. [Before that] we were never very involved in the budget, but rather we were told what money would be allowed for the year. We would copy our spending from a computer report onto another computer sheet and send it to the director. We didn't worry about money. Earlier on, when we were told to watch the budget, we would try and pick up some things to do. Instead of using styrofoam cups from the supply cupboard we brought in our own mugs. No big deal. We reduced the number of tongue blades we used. That was as serious as we got. But then we started to realize that we had to really work on it.

1990 is probably the year most people in the hospital would still remember as when the major changes occurred. All the head nurses were let go, except a few who were kept and moved into these new manager roles. In our division, we went from about 23 down to eight. So I went into job sharing. Two of us did full time job sharing as managers of three units. I moved to a new area where I didn't know the staff or the physicians. The role changed. The unfortunate thing was that the physicians had been used to a manager being there who did everything for them. I had to keep explaining that the role had changed and budget was only part of that role. It was very challenging.

So we had more people under our responsibility and a bigger say in the budget. Some units became married together and others shut down. I had to do a lot of coaching and it took a tremendous amount of time. Staff felt demoralized and degraded. I worked at open communication: straight talk. We'd write the issues on the board and then in the middle of this readjustment there would be more layoffs. The grapevine is brutal. If someone had to move to another unit and had not been popular in their previous work place, people would massacre them before they even got to the new area. There were some strong staff, but others were just miserable. We lost a lot of supports like the IV team and the nursing office. That was when staff began phoning me at home. The nursing office used to help with things like viewing a body in the morgue, what to do if the media phoned, emergency staffing. So now [evening and nights] they [the staff] had no support.

One night I actually slept on cushions by the phone in the kitchen [at home] so I wouldn't wake my husband and kids. I would get the phone the minute it rang. At this particular time in the change over from one ward to three, a nurse was in charge at night and she wasn't very long at it. The resident was giving her a hard time about admitting a patient from emergency and she couldn't [do the admission] because she didn't have the staff. And there's no way a nurse in the float pool is going to come in at 1:00 in the morning. She was trying to run the units, trying to be in charge, but emergency and the resident kept calling her. So I told her to have them call me at home.

After a year, my job sharing partner went on stress leave, so I came back full time. At that time, they were looking for someone to do negotiations for the union and I was asked to do that. So I did. Then I filled in the director's job. And then I went to help with the design team [another project].

The part I enjoyed most about the patient care manager job was all the dealing with people, the connections with the units and the real live action. There were days, though, when I told them, "I'm moving my office downtown and I'm not going to have a phone so I can get my work done. And the door will not stop revolving! You guys! If I could just get rid of you and get this work done!" There was never a minute to yourself. I would joke with the staff. It's like when you're busy on the floor and you say, "If it wasn't for the patients you could get the paper work done."

So, then the department heads in all the other services were gone: physiotherapy and occupational therapy and social work. Those three areas were okay because they spoke to us and said they would like to look after themselves. They each had a professional council as an advisory committee to deal with concerns. They were independent practitioners. But there was a lot of confusion, when they lost their managers and directors, about how much responsibility they had. They really were responsible to the unit [to the patient care manager] but they still had a department downstairs, so they weren't physically on the unit. We acted more as a liaison with them.

Environmental services and dietary were more difficult. I realized there's no way I can handle all these people. The art of delegation became vital. They weren't used to operating independently. And some of them had these carts. They're like their second little home.

> They move them around. And if a different relief person came in and moved anything on their cart, they got upset. So we had meetings to deal with those issues. It was a challenge.
>
> Being visible became difficult. I found a lot of times staff were saying, "We don't see as much of you anymore as we used to." And I would try to start out...I used to do a little routine where I would come on, when I only had the three wards, and I would do this report: one ward, then the next ward the next day, and the next the next. So I'd see the nine nurses three days a week. Then for the rest of the week I'd just do office stuff. I wouldn't worry about seeing them at all. And then, after a while, that was getting hard to do, even with just the three wards, because you'd come in in the morning and immediately you had a ton of voice mail or whatever. And then you [had to] pop down to physio or pop into OT or pop down to the lab or one of the clinics or whatever. If one week went by and I hadn't seen everywhere at least once, it was easy to see the wards, because if I passed by the central area...without thinking about it you have your visibility. And people noticed when I wouldn't appear.
>
> But I suppose, in a way, sometimes being a manager is like being a mother, you know. You have one child and you focus a lot of attention on that one child, the good, the bad and the ugly. And you can deal with everything. And then you wonder how you're going to love another child or fit another one into your schedule. And you just do. And then you don't even wonder about the third child anymore. You just throw it in. And so many, many times I thought it was very similar, that there came a point in the job where you knew you could handle anything, but you really had to priorize [and delegate]. It became vital to your existence.

Summary

These accounts offer only a glimpse into the complicated, often frenetic work world of the PCMs. They begin their days early and end them late. They carry on at a torrid place all day long. And even though they usually work on through breaks and lunches and after others have gone home, often much of what falls to them remains undone.

The commonalties of complexity and pace in the work of these four PCM's which will be analyzed in the next chapter are summarized as follows.

Leadership	Downsizing	Quality Care
• communication • team building • delegation • meetings • coordination	• layoffs • union negotiations • bumping • staff morale • boundaries of control	• staffing • research • education • support

Scope of the Role

However, the stories above reveal more than the complexity and pace of the environment in which the PCMs operate. They hint at the next commonality as well, the wide range of issues and concerns those in the role of patient care manager must deal with each day and the broad base of abilities they consequently need. The fiscal, material, and human resources of all their units are under their management. On top of obvious nursing care responsibilities, educational, research, promotional, environmental, transportation, technical, and personal concerns are in their purview too.

It Wasn't Always This Way

It quickly became apparent during the course of my field investigation that, at its present stage of development, the role of patient care manager at this hospital is a role that is in transition. Just as the expanded role is relatively new in the history of patient care, it is new to the PCMs I observed and interviewed too.

> …the role of the patient care manager is changing and has changed…I now have six units rather than one…. Added to that, I have an outpatient unit and several other disciplines such as

> dietary technician, physiotherapy, environmental services, housekeeping. (Jackie)

> The role at that time (five years ago) was so simple. I worked with the unit clerks, did rounds with the physicians and knew everything about the patient. The only real challenge was that I was new to the job...and about four years after being a head nurse, there were ripples of change. I became a manager of more units. The role changed. As I became responsible for more units and more people, I also became responsible for the budget. The relationship with physicians changes. (They) had been used to a manager who did everything for them from counting beds to blowing their nose. (Anne Marie)

> When you used to be the head nurse, you had your own unit. You did rounds with the doctor and you were clinically the most competent. You knew everything about the patient.... As some head nurses became patient care managers...it sort of evolved...some were uncomfortable doing budgets.... That is usually not what they got into nursing for. But now, they can't go back to being a staff nurse...and they have a mortgage or kids or whatever and it's their job, so they function. (Kate)

One of the most obvious points both discussed and observed is that the traditional work role of nurse managers is expanding. But the more the new role was studied, the more obvious it became that its parameters are somewhat unclear and that some of those who are touched by the transition are unsettled. If the boundaries of the new role are confused, those who work with them are as well.

> I think it has been very difficult for the people who lost their supervisors and managers. They feel like they lost a lot of identity and are floundering. They're all kind of out there now, doing their own thing, under me. (Jackie)

> You get a team working well together and change is good but at the same time when the team loses three, six, or nine members and has to get used to new ones and you don't really know what the skills are like for a while, it's really threatening to the staff. (Anne Marie)

Downsizing

By now it must be obvious that much of the time and energy of the PCMs I studied was focused on solving problems revolving around the related issues of reduced budgets, lay-offs, shortages of materials and staff, and increased demands on the staff that remain. Perhaps all of these issues are best viewed as aspects of health care reform which clouded the entire study, much as it clouded the daily work lives of the PCMs, the issue of downsizing, or fiscal restraint.

> ...each time we did layoffs we were losing at least 3 or 4 from this ward, and 2 from this ward. That was really sad because you lose the fresh, young blood. Sometimes they would be refreshers and it didn't matter because they would have this enthusiasm. (Anne Marie)

As Canadian values and expectations relating to health care come under evaluation in response to world and environmental changes, changes in the health care system are ongoing, inevitable and pervasive (Andrews et al., 1994). Quality care must be achieved within the constraints of economic reality (Garner et al., 1990, p. 129). But it is the PCMs and those in similar positions who must implement the changes. And they are ultimately responsible for care. Therefore, it is on them that much of the impact of these changes falls. One of my participants put it this way:

> The job itself is very challenging. I'm learning new things every day because I don't think nurses ever learn how to be managers. There's new challenges. It really stimulates the thinking, problem solving, decision making, and some pretty major decisions related to some pretty hefty dollars sometimes.... I sometimes get discouraged because they (the staff) have a very pessimistic point of view, perhaps because of the transition. It seems to relate to the cutbacks. Staff are immobilized with anxiety about fear of the unknown. This anxiety becomes contagious. (Linda)

After long deliberations with other PCMs and union managers about which nurses to lay off and the resulting grievances, another of my participants said this:

> It affects me physically, a tightness in my chest. I know how people are hurting out there. I guess it's really important to me…to be able to say to people we were as fair as possible, we thought we were doing something the right way the first time. In retrospect, I still think its the right way. But there are too many people that are hurting for it to ever work…. When you're making decisions, the theory always says you have to look at what all the options will be. (Jackie)

Jackie is referring to a plan the managers as a group had devised to deal with downsizing on several units. They were going to merge two units rather than treating each separately. In this way, they felt they could reduce the number of staff that would be laid off in this specialty area. However, the union did not agree, and had filed grievances the day after the plan was announced.

Sometimes, I was told, staff on nursing units have been "reduced to raiding resources" by recent cutbacks. Nurses working for one of my participants and the PCM herself supplied these details:

> It's Saturday, 3:00 p.m., on a busy unit which has two groups of patients daily, one in the morning and one in the afternoon. The morning group is finishing up and the afternoon group is ready to begin when the staff discover that there is no linen. The cart, which was to be delivered at 9:00 a.m., isn't there. Meanwhile, beds have to be changed. Without the linen, no nursing functions can be done. A call to the materiels management area reveals there is no linen cart for the unit there either. Nor has it been found when, after a wait, someone phones again.
>
> Convinced there's been a mistake, two nurses decide to track it down. But at the materials management area they have no luck. The gentleman at the desk doesn't approach them either, so they stand there debating what to do. They can't see themselves going back empty-handed. Chaos will reign there. Linen is just that important. Without it, the work of the day can't be done.

> Just then, a truck arrives to deliver linen for the following morning, backs up to the loading dock, opens its back door, and lets down a ramp. The two nurses see their chance. They climb up onto the loading dock. No one spies them. They sneak up behind the truck. One climbs in. But as the other tries to join her, the truck jerks. The second nurse falls off the ramp. Her partner screams and jumps down to her side. She isn't badly hurt.
>
> The nurse manager hears of it the next day. She's responsible for the nurses. She could have faced a Worker's Compensation claim. Fortunately no one had to take time off. She meets with both of them, making sure they understand how dangerous their actions had been. But she's responsible for resources also, so she calls a meeting with the manager and staff of the Materiels Management department.
>
> She books and sets up the room, informs all present, and invites others to contribute as well. The materials department manager asks his staff what happened. No one seems to know. The PCM writes pertinent points on a blackboard, keeps discussion centered on the basic goal of ensuring a supply of fresh linen...without nurses having to go to such lengths to get it...and encourages the materials management department staff to come up with solutions. The meeting seems to be productive, but at a later date it became evident that the problem wasn't solved.

In Charge and Getting Paid

> ...in the olden days they would have just phoned the nursing office. I mean, they were so disempowered. Like, they really didn't have to make decisions. (Anne Marie)

As this quotation from one of my interviews suggests and as the material in Chapter 2 describes, health care has a history of hierarchical, authoritative management models. However, a major influence on the current transition, the total quality management model, advocates self governance and decentralization. In the case of the evolving patient care manager role, this has inspired the sharing of decision making and power.

> In the beginning there were a lot of phone calls at home. People would phone and ask for advice. I'd keep asking them questions. What would you do if...? Actually, a girlfriend of mine was visiting one night when I was at home and I spent 45 minutes, I'm sure, on the phone with the nurse. It was really quite funny because I would say: "Okay, have you thought through bringing help from other wards?" "Have you thought about changing the assignments?" "Have you thought about whatever?" You know. And I could tell she was half listening and half not. So I said, "I suppose the bottom line is *that you're in charge and getting paid to be in charge and I'm not in the building.*" ...It was like this mother thing. I didn't want to be fussing and phoning during the night. So I went in the morning a bit early and...she told me what she did. And she said, "Is that okay?" And I said, "Yeah, that's fine, you know, good move." And she was really pleased with herself. And after that she didn't phone as much. There were several of them like that. (Anne Marie)

But sharing decision making and power is not always easy. Anne Marie tells of trying to decentralize one group of services (environmental services) into several areas and having to recentralize it back for reassessment. She said, "They were used to being led. Well, not led, but told what to do." Nor is shared governance necessarily achieved all at once or to the advantage of the manager's workload, as Anne Marie's story attests. On the contrary, implementation of shared governance requires considerable development of skill in staff and considerable skill on the part of the PCM for this to be achieved.

> ...this is where I feel really strongly what the patient care manager role is and how the patient care manager's role changed. I spend a great deal of my time team building. It becomes a real challenge to remember all the staff that you have to talk to. But, you know, I don't want to take people away from patient care, etc., for no reason at all. In terms of team building too is the recognition that I can no longer just be sort of biased towards nursing, do you know what I mean? (Jackie)

> I'd have to try and coach them through. And really a lot of it was those phone calls. A lot of them would phone and tell you what

> they'd done...and I'd say, "You know, I'm really proud of you. You did a really good job last night. But...you can just tell me in the morning or leave me a note." Without saying please don't phone me at 11:00 at night to tell me. (Anne Marie)

> One of my biggest jobs when I came here was...to make the staff less dependent.... Like, you are not their babysitter. You have to push them to make independent decisions and not dump on you, because they will! They will go ahead and do all their patient care for the day, but they will bring you all the problems. And you don't need the problems. You've got enough. You give it back. And you have to figure out how to do that. (Jackie)

You Hear it All

> I think I can make life a little bit better for a group of staff and that if I make life better for them, they will make life better for the patients. (Jackie)

Garner et al. (1990) point out that as nurses and other staff confront the demands of resource-restrained work situations, a great burden is placed on those remaining to provide exemplary care. But change can be unsettling in any setting. And the changes in the financing of health care have produced a climate of uncertainty and pessimism about the future for nurses (Garner et al., 1990). This impacts on everyone involved.

> They have a very pessimistic view, perhaps because of the transition. It seems to relate to the cutbacks.... Staff are immobilized with anxiety about fear of the unknown. This anxiety becomes contagious. (Linda)

Anne Marie has found it is contagious too. "One of the hardest things the staff had to deal with, and we had to help them with," she says, "was trying to stop them talking about the situation on the floor, around the desk area, on the elevator." Another problem is that often nurses have too many patients to care for. Casual staff that fill in may not know the area well.

> The other day I had a conversation with a nurse who was really upset because of another that was assigned in one unit. She didn't think she was trained at an appropriate level. My response was that I had talked to this other nurse and she, the first one, was correct. She had not been prepared. But she was willing to come and help a unit desperate for staff. She just needed a little bit of…she needed someone to be assigned as a resource and just a little bit of guidance…. The other option was no nurse. (Linda)

Wage rollbacks can wreak havoc with morale as well. Support is needed for many reasons and by different groups. And, more than ever before, it falls on the patient care managers to provide it. One of her greatest tasks in this climate of uncertainty is to maintain morale.

> Before you always just sort of sat and listened to the problems of nursing and always tried to, you know, you tried to deal with them with the other services. *But now you hear it all.* And it really does put things into perspective. And I guess the best example I can give you is when they assigned the dietary technician to me the other day. It was interesting because they were asked what their major concerns were. And, of course, it was diet changes and updates. And it was like, gee, you know, I mean those are things nurses complain about on the units…. I thought, my goodness, we should be able to come to some resolution on something. We have the same goals. (Jackie)

But support can be provided and morale maintained in different ways. One of those ways the PCMs I shadowed rely heavily on in dealing with their staff is communication. "I always used to leave the phone open and say to them, `If you need to phone…'," Anne Marie told me. Jackie said, "You know, information and knowledge is control."

> I found…that in each group there was kind of a hidden leader. And I tended to develop a very strong rapport with some of those people. And then, with their help, would work around the communication within the groups. (Anne Marie)

> I seek input for change from all the staff and keep them informed about changing conditions in the hospital. I try to balance the organizational goals with the nursing goals by supporting the basic

> values of nurses toward patient care. And I treat each staff member with dignity and worth as individuals. (Kate)

But it is not only the staff that need the patient care manager's support. Sometimes patients and their families need support too. It has already been related how Jackie handled a patient's relatives while I was with her on rounds. On another occasion, she did the same for the daughter of a patient who had just died. "I've been in the situation, losing both my parents, and in…a hospital that was absolutely outstanding, the nurse support," she said.

Off a Turnip Truck

The issue of conflict within the health care team occurred to me during an interdisciplinary meeting with physicians, nurses, and other staff while I was shadowing Kate. Differing views on patient care, especially between doctors and nurses, had been expressed. So afterward I asked Kate about that. The first point she made in answer was that her primary commitment is to the overall process of providing patient care. But she admitted to the existence of conflict. She provided examples too.

When Kate initially became patient care manager in that area, the physician director spent more time in his office than on the units, which aroused negative feelings in the rest of the team. Kate asked for a meeting. "I pointed out to him that to be a director means more than having one's picture on the wall," she said. Since then, they have "ironed out a few difficulties" and he has become very supportive of her work.

The second example related to her role in budget cuts. At the time she assumed her new role, she was told she had to save one and a half million dollars of about an eight million dollar budget while providing the same

services to patients as before. She worked toward that goal and, in fact, achieved it. But the physicians were what she called "a hard sell." Some didn't like her cost reducing measures, which she had seen in other hospitals, or her taking over price negotiations for large supply contracts. So Kate had to negotiate with each individual physician too.

> I negotiated for each one, and with each one, in order to convince them my ideas would work. A positive relationship has resulted. I feel I had to prove myself in order to achieve the kind of relationship that is available to them and to me now. Physicians didn't want to hear such things from a nurse. But they didn't mind having a say in nurse staffing. I feel nurse staffing decisions are nurse decisions. They should not be doctor decisions. I think I'm considered an overbearing woman because of my futuristic ideas. I know this idea will work! *Do they think I fell off a turnip truck?* (Kate)

Linda had conflicts with physicians, and over staffing, too. She told me that sometimes she met with them on a daily basis in an attempt to work things out.

> They don't always...how can I put this succinctly? Physicians tend not to have a good understanding of staffing requirements, staff availability, collective agreement, clauses...they can't seem to integrate all of that. In their mind, they just want a nurse in the room looking after a patient and any other thing that has to do with that, they just don't want to hear it.... It's very stressful on me. I don't think it's stressful on them, but it's extremely stressful on me. Yesterday I went home and I was...I was almost sick, I was so stressed out over staffing. (Linda)

But not all of the conflict is between physicians and PCMs. Linda has found what she describes as "a fair amount of conflict between the staff themselves" on both of her units. She attributes this to "an inability of staff to be able to address each other about some of the concerns they have." She handles it this way.

> With two or three people who have come to me about major concerns related to another nurse, I've talked to them about how they could address that person, how they need to pull themselves away from the scene. I've given them some hints on how to start the conversation, what to watch for, how to end it, when it needs more intervention.... And some of the staff will say to me that they're willing to try that. But most of them do not feel it's worth the risk. They feel that it will just add more conflict. As nurses, we're not good at dealing with conflict. We're good at dealing with families and helping them work through conflict related to illness within the family. Yet those same people cannot address their co-worker who's standing ten feet away.... (Linda)

Sometimes, however, the conflicts are common or ongoing problems with what Linda calls "people who everybody complains about." Concerning them, she tells her staff this:

> ...for years and years you've allowed this person to behave this way. Everyone has allowed this person to do whatever she/he is doing.... So you can't just walk up to them all of a sudden and say this behavior is no longer tolerated because you've given them a message for years and years that...whatever they're doing is okay. And now all of a sudden it's no longer okay? It makes it very confusing and it's just very difficult to deal with it after that. (Linda)

Summary

The position of patient care manager as it has evolved in this particular setting so far is a vast, sprawling role that spans many, varied functions, demands a lot from those that occupy it and continues to change. It is a position that also raises the question: what sort of person would take on the job?

The commonalties of this theme, scope of the role, which will be discussed in the next chapter include the following.

Transitions	Resources	Empowerment
• changes in role • professionalism • feelings and emotions • coping abilities	• providing resources • integrating groups • organization goals, nursing goals	• coaching staff • conflict management • advocacy

Who Are They?

This is a question that probably cannot be answered precisely. The patient care managers I shadowed are individuals. Each is different. It would be impossible in a study such as this to learn everything about them. But just as there are commonalties in their experiences, so there are commonalties in the participants themselves. The most striking are similarities in how they present themselves, their professional backgrounds, their attitudes, their outlooks, and their responses to their environment, experiences, and roles.

They Look Good

One of the first things that struck me about the four PCMs I shadowed and about other patient care managers that I did not was a correspondence in their presentation, their appearance, manner, and speech. All dress neatly, professionally, in designer suits. All wear their hair in styles that are current, appropriate to both hospital and business settings, and easy to keep. All walk quickly from meeting rooms to the bedside with confidence and ease. All can speak elegantly or toughly, as situations demand. And all can offer a soft

touch or word to a patient, or a cup of coffee to a relative, with gentleness and genuine concern.

"You know the old saying, `Live hard, die young and look good!'" says Kate. As to the last part, they certainly do.

Opportunity Was Put My Way

I also found it interesting, on getting to know the participants, that most did not anticipate or plan a career in management when embarking on their professional education. Three of them chose nursing as a career and got into management, sometimes unintentionally, later. One of them carefully planned her career and her move into management.

Linda was one who aimed straight for nursing. She attended open houses, consulted school counselors and selected a nursing school, mainly on the basis of a private room in residence being offered. A management role came to her many years after.

> I gradually built my skills.... I started working on a degree, took a year of travel, moved again...came an opportunity to work in yet another speciality ...began a master's degree...applied for several jobs...I took this job, really my first management job, and I've been here for five years. (Linda)

Anne Marie came to Canada from another country and began working as a staff nurse. "I had no career plan and had not thought of doing this," she says of her new role. "*Opportunity was put my way.*" Jackie, on the other hand, makes it sound as though she slid into the role, or as though circumstances or other people landed her where she is today.

> I ended up in this position because, not because I had goals set...to be a manager...but because...of being put in situations that...people started to respond to me. And through the staff in one

> unit, you know, they felt that I could be their manager and that I would do a good job. They asked me to apply.... (Jackie)

Kate is the sole exception. She did it the opposite way, although her present role was not envisioned from the outset.

> I didn't take nursing first. I took business administration first. Then I went to graduate school and did some of my MBA and a few other things.... I never wanted to be a nurse, but I wanted to get into that environment somehow. So I applied to nursing school and from the first day, I absolutely loved it. (Kate)

I Will Get it Done

Aside from being people of high energy, as the job demands they must be, the four participants resemble each other in aspects of their personalities, especially in their attitudes, in certain significant ways also. All have the ability to concentrate on the task at hand despite the multitude of conflicting demands that surround them. "You have to...always be focused. You have to concentrate on every interaction.... I'm human, I do forget things," Jackie says.

All have a strong measure of confidence. Kate says, "I know how I work and how I accomplish things. I know *how* I get things done and that *I will get it done*...on time. I have confidence in myself." Linda exhibits it in her determination to instill a sense of responsibility in her staff, as discussed above. Kate shows it again when resolving conflicts with the doctors. On one occasion, she urged a panel of doctors to come up with their share of budget cuts, by beginning, "Okay, boys! Today is the day I see your money on the table!"

All have high expectations too. They don't exempt themselves. "I think I can make life a little better for...staff and that if I (do)..., they will make life

better for the patients." Jackie says, adding, "I have very high expectations of myself in terms of how I appear to people and I will not go onto the units if I am not in a positive frame of mind. And it's forced at times." But her high expectations extend to her staff as well.

> I would never demean anybody for asking me a question, but in the back of my mind I do think, "You are a professional. You can think this one through for yourself." You have to pull this out of people sometimes. She can be more if she wants to be. I have an expectation that every person on the unit should be able to take charge. (Jackie)

Commonalties in the characteristics of the patient care managers I studied—focus, confidence, high expectations—are keys to understanding how they handle the pace and complexity of the environment in which they work and the demands of the role they occupy today. "I like it when things are happening, like when there's an emergency and that kind of thing. I get this sort of burst of adrenaline," says Kate. "I thrive on the chaos," says Anne Marie. "I function much better when I've got five million things to do."

Flying by the Seat of My Pants

One of the most important things I found that these four patient care managers share, though, is a keen, forward-looking perspective. When I first witnessed the pace at which they function, I wondered if anything they did was planned or if it was crisis management, a rush from one thing to the other that I was observing. But the more time I spent with them, the clearer the answer became. In different ways and in different degrees, they are people of vision, every one.

> I know that (with) a lot of things I always tell people, "I don't know. I think I might be *flying by the seat of my pants.*" And that's what it seems like a lot of times, because I sort of have in my mind where

> we need to be and I have a plan, a sort of big picture. And then as things happen, I just respond to those things and I can manipulate certain things in a certain way so that ultimately we get to where we need to be. And it kind of looks like it just happened. (Kate)

But setting a vision, much less following it, is difficult when the working environment is so fast and complex and the demands of the role are so huge. Kate squeezes her planning in this way:

> I do my critical reflection at 3:00 in the morning or driving home or on the stairmaster riding the treadmill if I go for a run. A lot of times I can't get back to sleep, so I just kind of lay there and plan my day. I think, "In six months time, we need to be doing this." When I came here I thought, "What do I need to accomplish in three years? What can't I stand for the next six months?" And it's all worked out fairly well. (Kate)

Linda's situation is slightly different. Her visible presence in all areas is of utmost importance to her staff. "I have four sets of critical efficiencies that I am involved with," she says. "Program development of where each different speciality is going, new procedures, serving seven different areas, and being there for the staff. They very much want to see me around." So the formation of her vision is an ongoing process. Vision follows learning for her. But for Jackie the day-to-day issues are of such magnitude, that on-going, long-range planning hardly has room.

> Looking at the multidisciplinary arena for the other disciplines that work under me, and being interested in all that they do, takes time. I delegate to the clinical supervisors and the director of patient care delegates to me. When she's away, I deal with big issues for her. This week I'm looking at an early retirement package for one person, acupuncture in the hospital, patients referred by physicians that require services we have not budgetted for. The issues are big. And they never seem to end. (Jackie)

If I'd Hardened Up

The patient care managers seem, and truly are, I believe, strong people, thoroughly professional. Each can present themselves, as circumstances demand, as poised, determined, visionary, confident, and focused. They chair multi-disciplinary meetings. They prepare reports. They negotiate contracts. They liaise with many levels of administration within their own institution and others. They conduct research. They are almost always in control. They act tough sometimes. Yet my time with them revealed that each of them has a soft underside, vulnerability a simple interaction can trigger that casual observers don't see.

"I'm about that close to tears," Jackie tells me after a meeting with the relative of a patient who died. "And I usually am at the end of the day." She's not alone. Anne Marie describes what happened in a staff meeting one day:

> I was standing up there and we knew that the next thing that was going to happen was that one of us was going to be gone. So you'd start out telling your staff that there were going to be layoffs. And we even knew X number of full-time positions would be affected. And I actually broke down. The tears just started flowing. And one of the nurses passed a box of tissues and I just kind of dabbed and said, "I'm sorry, but this is really hard for all of us and I know it's very hard for you and it's also very hard for us and it's not a comfortable thing to have to do." (Anne Marie)

Sometimes, as above, it is the pressures of downsizing and the loss of friends and colleagues that does it. "It affects me physically, a tightness in my chest," says Jackie. Anne Marie finds it difficult too.

> ...people are worried about their jobs and their homes and everything else. I think, too, the longer you're the manager, the better you get to know the staff. And I think, too, over the years maybe it's becoming harder to go through the layoffs because you knew everybody's personal problems which came out of the wash.

> I think that made it quite draining. And very long hours. (Anne Marie)

Sometimes it is simply a matter of fatigue, of the complexity and pace of the environment and the demands of the role taking too much of a toll. "I do everything the same, flat out," says Kate, "but I also have down time, like when I just kind of crash." "I feel really tired now, kind of exhausted," Jackie told me after the incident mentioned above. "There are some days I've put in sixteen hours. I get physically tired. And emotionally tired," Linda relates. And Kate admits, "...when I'm driving home I'm tired, like physically tired...there are times when I think I would really like to have tomorrow off just to sleep...I *need* to sleep."

Perhaps Linda put it best, though:

> When you get home, you're almost too tired to do anything. I know that my family is very upset with my lifestyle right now. Other things I know I could do I just don't do because I'm too tired to do them. I know last night I thought, "Gee, this looks like a nice evening for a bike ride." But I'd have to haul my bike up from downstairs. And I just sat there and thought, "I just don't have the strength to lift that bike up those stairs." (Linda)

Sometimes there is a sense of isolation, even a hint of claustrophobia there, too. I noticed the offices of the PCMs, indeed much of their workplaces, have no windows. When I mentioned that to Jackie, she recalled that once, "I just said, `I you know excuse me, but I need to get out of here.' And I just got up and walked outside." The world passes her by in another way too.

> I find it's very hard to talk about anything outside of work. I didn't know until this weekend that Vancouver could actually win the Stanley Cup. I knew they were involved but I didn't know we were that far along at the finals. It's very isolated. I read Friday's and Saturday's and Sunday's newspapers this weekend. And that's the only news I get in a week. (Jackie)

Each PCM has ways to cope. All are physically active when they get a chance. Linda walks and would ride her bike if she could. Jackie runs. Kate also runs, uses the stairmaster and treadmill, and, when away at conferences, is "the last one on the dance floor." She finds she needs quiet time too, though: "I read, listen to music and hang out myself." And Anne Marie does something unique. To unclutter her mind, she occasionally takes what she calls a "cruise day," to walk her units with no fixed purpose, talk to patients and simply observe.

However, all rely on the support of others as well. Jackie likes to phone her grown children and certain close friends. Kate phones other PCMs about problems, goes for a late night coffee with colleagues and depends strongly on her husband, who she says is "my biggest fan." Anne Marie spends as much time with her young family as she can find. And sometimes any one of them might find support right there in the middle of the work-place, from the most unlikely of sources too.

> Like, one nurse, every time we did layoffs she'd bring me in a bag of chocolate and she was laid off twice. So, in the middle of this mess, people would come in and ask *us* how *we* were doing. You might find a rose outside your door. I found a bottle of gin outside my door one day. I used to say to them, "You guys just blow me away." (Anne Marie)

For various reasons, Anne Marie is no longer in her PCM position. "I think" she once began to tell me, *"...if I'd hardened up...."* But she didn't finish what she was going to say.

Summary

Who are the PCMs then? Their own words, deeds, and stories show they are different things, different people. But they are, at the least, focused,

confident individuals of high expectations and vision, who generally did not plan to be in the roles they occupy today. They are also vulnerable people, subject to fatigue and isolation, and sensitive to the hardships of their patients and staff.

"We're human," said Anne Marie.

The commonalties of this theme, who are they, which will be discussed in the next chapter, included the following.

Move into Management	Individual as Leader	Dealing with Stress
• opportunity • career planning • belief in self	• presentation of self • professional background • attitude and outlook • vision	• fatigue • isolation • vulnerability • support

CHAPTER 5

Writing And Analyzing The Narrative

As mentioned at the outset, the aim of this work is to provide insight into the working lives of individuals in the role of patient care manager in a large, acute care hospital setting. Much insight can be gained directly from the data themselves, namely through presentation of the participants' accounts and explanations of their experiences and the researcher's observations of the context in which those accounts occur. To some extent, the words of the participants can speak for themselves. But the methodology of narrative transcends the mere collection of data. The task of seeking meaning does not stop there. It also entails explanation from the researcher's perspective, the forging of links to pertinent literature, and, wherever possible, the making of meaning or sense of the recorded observations and accounts as a whole.

This endeavour, the third step in the narrative inquiry process, is referred to in various ways by those who conduct qualitative research. Some call it writing the narrative. Others call it analysis. Often it is simply referred to as interpretation. The prominence of the two terms in widest use currently, writing and analysis, is acknowledged by inclusion of both in the title of this chapter, but 'the process of analysis' is the terminology I prefer. In any event, often some or all of these terms are used interchangably in the literature. All aptly denote the search for understanding too. Therefore it is not important

to this discussion to argue for one or the other and all will be treated as interchangable here.

As the purpose of the last chapter was to present and place in context the views and experiences of the four patient care managers who participated in this work, then, the purpose of this chapter is to highlight and examine commonalities in and any fundamental differences between their accounts, so that their stories and opinions, individually and collectively, make sense. Before attempting to apply the analytical process to the wealth of recorded material summarized and highlighted in the previous chapter, however, it is worthwhile to consider what the process of analysis entails and how it establishes the narrative within a period of time.

The Process of Analysis and the Place of Time

Huberman and Miles (1994) make the point that the process of analysis in narrative inquiry, which they refer to as the craft of writing, managing and writing data from a qualitative focus, is gradually becoming explicitly shared (Huberman and Miles, 1994). The descriptive and explanatory aims of this type of study are reached, they claim, through a process of data transformation which occurs as information is condensed, clustered, sorted and linked, allowing one to move inductively towards patterns of relationships. These authors also suggest that qualitative studies tend to have a peculiar life cycle which spreads the collection of data and analysis throughout a study (p. 431), and analysis is actually set in motion during the first visit as margin notes are made on field texts and plausibility is questioned with an intuitive sense. The implication for this research is that analysis commenced with my first step through the hospital door.

Clandinin and Connelly (1994) write in a similar vein, arguing that interpretation occurs in the transition from field text to research text and that stories, as they are lived, told, relived and retold, are modified in the retelling. Field texts are "more or less collaboratively restructured, may be more or less interpretive and may be more or less researcher influenced" (p. 419), these authors point out, so the task is to discover and construct meaning in the research texts reconstructed from them. Since these research texts are close to the experiences recorded and are descriptive in nature, they are shaped by a search for patterns rather than by a reflective intent, Clandinin and Connelly (1994) add, apparently in an attempt to establish that the risk of bias inherent in any reconstructive undertaking is actually quite low in a process such as this.

There are, though, no fixed ways of separating initial analysis from final analysis, as both Huberman and Miles (1994) and Reissman (1993) point out. The former also argue, though, that two levels of understanding, descriptive and explanatory, may help in the analysis: descriptive data answers questions about what is going on and how things are proceeding within a certain context; explanatory comments provide reasons, justifications and support for actions, claims and what otherwise might seem like casual remarks. Explanations are context dependent therefore (Huberman & Miles, 1994) and the written text that emerges influences the researcher's conclusions, helps to see patterns that can be analyzed and may lead to new relationships and explanations.

Another way in which analysis leads to insight is by establishing a temporal context for the events, situations and perspectives discussed in both

the field text and the research text. Clandinin and Connelly (1994) talk about time having a backward and forward dimension, namely a past, present and future, and an internal and external dimension, which focuses inward on feelings and hopes and outward on the environment. This is particularly important in understanding the work of the PCMs, as their role at the time of this research was very different from that of their predecessors, was continuing to evolve even then, and was under expectations of facing further changes still. These further changes have taken place, in fact, such that the precise conditions these PCMs worked in, even the role itself, might not be experienced again.

The importance of establishing a temporal context is most apparent in reflecting back on the historical background to nursing leadership roles presented in Chapter 2 and how hospitals in the past were established to meet the needs of the communities then. In times of settlement, the needs were simple compared to those of today. Populations were small. Few nurses were needed and the capacities in which they served and their specific duties were widely varied. The 1930s and 1940s brought high unemployment among graduate nurses along with increased use of maids in hospitals to fulfil non nursing duties. In those times, the nurse in charge was expected to oversee a multitude of tasks and a broad range of disciplines, to be "a specialist in procedures, a chemist, a tactful executive, a general superintendent of nurses and maids and a go between of dietitians and social service assistants" (Henry, 1939).

The authority of the nurse manager, on the other hand, has been limited in the past (Kerr & MacPhail, 1988), as the vertical dimension of the hospital

organization meant that most of the authority existed at the top of the heirarchy. This affected the accountability of nurses at all levels too. Control tended to be centralized. It is clear that the responsibility for provision of quality care rested with the nurse in charge. One of the earlier methods for provision of care identified in the literature (Kerr & MacPhail, 1988) is that of functional nursing, in which tasks such as monitoring of temperature and blood pressure were assigned by the nurse in charge to staff based on their level of competence. But nurses at the bedside had little opportunity to make decisions or to influence organizations in respect of systems for delivery of care in the past (Giovanetti, cited in Kerr & MacPhail, 1986).

The present century, however, has witnessed a shift toward decentralization in both organizational structure and lines of authority. The development of primary nursing with a flow of accountability from one primary nurse to another, discussed in Chapter 2, is an example of that. Some parallels with the past still can be discerned in contemporary nursing assignments as levels of competence vary among staff, especially with the increasing trend toward employment of non nurses in care situations. But now that more responsibility and authority has been decentralized to the bedside nurse, the focus of nurse leadership has tended and continues to tend toward helping nurses accept and use that authority widely. An ongoing process even today, issues connected with this transition in authority and responsibility quickly became apparent in this research as major challenges faced by the PCMs studied here.

The historical accounts, then, reveal both changes in the role of the nurse leader and one significant constant, namely that it has always been a broad

ranging role that was, and is, filled with a variety of duties and demands adaptability, flexibility and the capability for a wide scope of activities on the part of whoever fills it. It is also a role which has been subject to a number of social and economic forces, echoes of which can be discerned in what is happening in health care today.

Complexity and Pace

As discussed in the previous chapter, one of the most obvious commonalities observable in the experiences of the PCMs is the fast pace and complexity of the world in which they work. This was both obvious to the researcher from the beginning of the field experience and expressed directly by the participating PCMs, as related in Chapter 4. This did not come as a surprise, however. The complexity of the role has also been recognized in the work of Beyers (1991), Dunn and Schilder (1993) and Morath and Manthey (1993). Dunn and Schilder (1993) found work activities and challenges of nurse managers to be anything from "heavy and unpredictable" to "incredible".

As it is the purpose of this study to enhance understanding, it is appropriate at this stage of the inquiry to consider whether reasons for the complexity and pace of this role can be found and to identify them if they can. The literature on this subject helps to some extent, indicating that one of the contributing factors is the dual, sometimes competing, foci for the work of PCMs: nursing care and management duties. These two roles have been called essential and pivotal (Duffield, 1991; Patz et al., 1991; Dunn & Schilder, 1993). Frisch et al. (1991) point to problems with control and uncertainty, concerns about competence and insufficient resources. Ponte and Capodilupo

(1992) write about larger and more diverse areas becoming the responsibility of those in nursing supervisory positions.

To the researcher, it was apparent both from personal observation and from the accounts of the participants themselves that a great many issues—including the obvious considerations of high volume and wide variety of work activities—contributed to, or affected the response of the PCMs toward the sometimes bewildering complexity and often frenetic pace of their role. Many of these issues are linked or even overlap, making them difficult to discuss in isolation. But, as it can be confusing to deal with several issues at once, three prominent issues within this commonality (leadership, downsizing and quality care) have been identified and sub-divided into their significant components. These were charted in the previous chapter (see p. 84) and are examined in greater depth here.

Leadership

The concept of leadership lies at the heart of this thesis. The role being studied was called in a particular place and at a particular moment in time "Patient Care Manager". Its predecessor has been called by various titles, including "head nurse", "charge nurse", "Sister Superior" and "Matron". A considerable variety of terms have been used for the managerial functions of those who were part of this lineage of roles too, including supervision, administration and 'being in charge'. In one form or another, however, it is nursing leadership of which we speak. And, although it is being discussed here as an issue relating to another concept, leadership itself is a complex thing.

Leadership is described by Naisbitt and Aburdene (1990) as "a democratic yet demanding activity that respects people and encourages self-management, autonomous teams and entrepreneurial units" (p. 218). These authors write that leaders must learn to coach, inspire and gain people's commitment, as well as to set personal examples of excellence as the dominant principle of organization has shifted from management in order to control an enterprise to leadership in order to bring out the best in people and to respond quickly to change. This reminds me of Jackie, maintaining a presence in busy times by making rounds of the units, watching how staff manage without interference, and teaching new things by demonstration, even starting a complicated IV line one morning.

Manthey (1990) enlarges on the these ideas in a nursing context, maintaining that as nursing changes from task-oriented to process-oriented and knowledge-based practice, leadership skills make the difference between effective and ineffective operational administration. The influence of leaders is not only in what they say, but in how they say it. Effective leaders possess well defined values, beliefs and expectations, can negotiate decisions by consensus, are skillful team builders and resolve conflicts constructively (Manthey, 1990, p. 40). As will be touched on later, all of the participants in this study demonstrated many of these characteristics in a number of ways.

Certainly all of the participants in this study consistently exhibited leadership in the form of commitment to the overall process of providing quality care. The challenge, as both Kate and Jackie pointed out, is to continue to provide optimum patient care in the face of all the changes they were undergoing. All had to juggle often competing responsibilitues and

demands, which they did with equanimity. All were respectful of their staff and colleagues, kept communication open, coached for self-autonomy, and praised and encouraged staff. However, the demands of the PCM role revealed five particularly important elements of leadership as summarized in Chapter 4 (communication, team building, delegation, meetings and coordination) which will be examined in that order here.

1. Communication. Communication in organizations has been described as downward, upward and lateral (Smith, 1994; Marriner-Tomey, 1996) as well as interdependent (Smith, 1994) and diagonal (Marriner-Tomey, 1996). Confidentiality and security are also important issues (Smith, 1994) as technologies such as electronic mail and facsimiles add to the complexity in security. In this study, evidence was clear about the importance and complexity of communication as PCMs tried to keep the work team informed about ongoing changes in the organization. Whether used informally, as in hallway or telephone discussion, or formally, as in the sharing of imperative information, communication was observed to impact on every other aspect of leadership behaviour. It was central to the worklives of these PCMs.

The forms of communication they used, moreover, were many and varied. Formal communication included responses to incoming mail, written memoranda and reports, written or telephone replies to requests for information, and attendance at meetings. Informal communication was mainly verbal and either on the telephone or face to face. A lot of time was spent returning voice mail calls. PCMs were called at home by individual staff members for advice and support and often were stopped for a word in hallways, where the business conducted was every bit as important as that

transacted through formal channels. The issues of teamwork, quality care and further downsizing were always being discussed. Clear communication was always required and provided.

Kate provides a good example. In her own case and that of her staff, several meetings were held to discuss further downsizing, about which there was much apprehension on the part of her staff. Kate pulled no punches when faced with awkward questions. On the contrary, she consistently provided information openly, honestly and dispassionately, sharing what she knew at the time, taking care not to indulge in speculation, but promising to keep her staff informed about changes yet to come. The promise was always kept and trust was earned.

As Manthey (1990) points out, however, content is not the whole of communication. There is importance in *how* things are said as well. Here the researcher's observations are especially important, as the way in which things are said is rarely revealed by the participants themselves. This is also an area in which all the PCMs I shadowed were most effective. The manner in which they responded to staff, colleagues, patients and family members alike was without exception direct, quietly authoritative, reassuring and calm. I never heard a voice raised in frustration or anger or witnessed a refusal to hear someone out.

This does not mean, however, that the communication of the PCMs lacked emotion. For one thing, composure of the sort they all displayed is an attitude with emotive content—that of confidence and self assurance—in itself. So is compassion, for another. As she herself related, Anne Marie revealed to her staff her own distress about their plight when having to deal

with yet another round of cutbacks. "I actually broke down. The tears just started flowing," she recalls. It is arguable that rather than weakening the group process, this display of sympathy actually strengthened it by stimulating a supportive response. Even directness can convey emotion, however, such as Kate displayed on one occasion when trying to get her point across to a group of physicians. "Okay, boys!" she began. They must have known just how she felt.

Another useful communication tool some of the PCMs used upon occasion was humour. Sometimes it was used simply to break tension, but it can and often does do a great deal more. Jackson (1994) writes that humour and healthy laughter play a constructive role within the climate of an organization and connect shared experience of organizational life, adding that recognizing and appreciating humour can also create a rich and versatile source of new knowledge. Johnson (1995) adds that humour can also be used constructively to influence human behaviour in health service organizations. It allows nurse executives to step outside themselves and their bureaucratic systems to view their situations from another perspective, and helps to deal with immediate issues and handle reality, as laughter presupposes a system of shared values and beliefs.

An example of effective use of humour, and thus of communication generally, in fact, is provided by a sign on the door of a non-participating PCM, which other PCMs and all kinds of staff and colleagues would read in

passing, frequently adding a chuckle or a comment. It reads this way:

You are not
totally,
completely,
irrevocably
responsible for everyone.
That's my job.

Love,
God.

2. Team Building. The cooperation of a large group of people is necessary to achieve the goals of an organization. As people are brought together into groups or teams, activities aimed specifically at building unity may be necessary to the development of a well functioning group. Teamwork as a viable option for accomplishing a myriad of duties and responsibilities is discussed by Sessa, Bennet and Birdsall (1993), who also point out, however, that working in teams can be a source of conflict and stress. These authors suggest that fostering an environment where mutual exchange of ideas can occur with the acceptance of differences and decision making/problem solving results should be the goal of team building efforts.

These ideas are especially pertinent to the large and diverse multi-disciplinary team the participants in this study were at the heart of. Team work was important to the provision of quality health care even before decentralization, but became even more so when increasing numbers of disciplines and individuals were brought together as parts of the patient care team. "I spend a great deal of my time team building," Jackie told me,

adding, "It becomes a challenge to remember all the staff that you have to talk to." Anne Marie relates, "I'd have to try and coach them [her staff] through [the changes]." And Linda echoes the point of Sessa, et al. (1993) about conflict and stress. "I was almost sick, I was so stressed out over staffing... As nurses, we're not good at dealing with conflict," she recalls.

A very clear example of deliberate team building comes from Kate, who called a general meeting of her staff while I was with her and asked about their concerns. The issues raised were many and diverse: taking patients to the morgue; teaching patients about medications; housekeeping; layoffs; and conflict with physicians. But Kate's response was clear, consistent and reassuring. She listened visibly. She made notes on all the issues voiced, praised work done, encouraged staff to keep going, and promised to work and report back on the matters discussed. She kept that promise, I was to learn, such as when she followed up on the linen issue by meeting with the materiels management department. She demonstrated that a key to building a team is earning staff trust.

Similar team building strategies are used by the other PCMs too. Linda makes much use of praise. Jackie makes opportunities to listen to her staff even as she roams the units, always thanking them for their input and proving her personal interest in them by attending informal gatherings too. This too earns trust. Linda also makes a point of team building gradually and continuously, constantly working on integration of new staff as they move onto the units following layoffs of junior members. During my time with her, she was concerned about an incoming staff member who had not yet made

contact with the unit. Each member matters to her. Attendance to each small detail builds the whole.

There is, however, another side to teamwork too. Gardner and Gardner (1992), who claim that value priorities and cultural attitudes form the basis for meaning and satisfaction for the work force, point directly to team building skills as a source of meaning and satisfaction for health care practitioners who have undergone a transition from clinical work to administration. This was not always obvious to me. Perhaps the role was too new and the burdens that came with it too heavy. But occasionally I caught glimpses of what those authors mean. "The part I enjoyed most about the patient care manager job," Anne Marie reminisces, "was all the dealing with people, the connections with the units and the real live action." Jackie says, "[The] satisfaction is being able to help solve problems for all these people." Kate doesn't even plan to remain in her position once she has made "a few more modifications" to the program. "After that, for me, as a professional, I've done it." she says.

However, there was, as I eventually discerned, another level of team work operating in the work environments that I observed. The obvious teamwork existed between the members of each PCM's team and was actively maintained and promoted by each PCM. But the PCMs also reached beyond the components of these individual teams. They reached out to each other, providing support in any way they could. They met to share concerns. They sought solutions for mutual and individual problems. As they would with their own staffs, they offered each other encouragement and praise. They even covered for one another on occasion. They themselves worked as a team.

3. Delegation. Delegation is the other side of the team building coin. Team building involves a conscious effort to bring both individuals and disciplines together for a common purpose. Delegation is a method of ensuring that the purpose is achieved by distributing responsibility and work. Each element of the team must do its part. In a nursing context, it has always been fundamental to both practice and leadership that delegation of responsibility be passed on to staff nurses for the care of the patient. The care delivery system requires nurse leaders to possess the key skill of being able to assess patient acuity and staff capability, and to fit the two together in order to provide quality care.

In recent times, however, delegation is becoming a more urgent issue in nursing practice because of changing staff mix and job restructuring (Huber, 1996). Care of patients is being redistributed and delegated within a multidisciplinary team according to Huber (1996), who defines delegation as getting things done through other people by transferring a task or procedure to someone else (p. 279). This is reflected in the experiences of all the participants in this study. Increasing demands and responsibilities left them with little choice but to leave many care decisions about patients with the staff members assigned to each. "One of my biggest jobs when I came here was...to make the staff less dependent," says Jackie. "I realized there's no way I can handle all these people. The art of delegation became vital," remembers Anne Marie.

The urgency of delegation did not make it easy to implement, however. "You have to push them [the staff] to make independent decisions and not dump on you, because they will!" warns Jackie, adding, "They will go ahead

and do all their patient care for the day, but they will bring you all the problems." "They weren't used to operating independently," Anne Marie reports of staff who phoned her at home during the night. She told them, "You're in charge and getting paid to be in charge and I'm not in the building." But delegation must be distinguished from abdication. Accountability for the outcome remains with the delegator, so it is important to follow up on the outcome of the delegated task. Despite her blunt words, Anne Marie slept by her kitchen phone, always ready to give advice, in those transitional times.

Perhaps the key to understanding delegation in this context is that, while nursing has long delegated performance of certain duties, the trend is now toward delegating a broader range of decision making too. This makes trust essential. Confidence in the skill of the person to whom the task is being delegated and a willingness to coach subordinates to improve their abilities is necessary (Huber, 1996). "I'd have to try and coach them through," says Anne Marie. Barter and Furmidge (1994) suggest that delegation requires supervision behaviours including being around, being available and helping the subordinate through the delegated task actions and decisions. This sounds like Jackie on her rounds, demonstrating the new IV, Kate integrating technicians into the team, and Linda even helping her staff with personal interactions, giving them "hints on how to start the conversation, what to watch for, how to end."

4. Meetings. The importance of meetings in the worklife of PCMs can hardly be overstated. At first glance, it may seem that they are really an aspect of communication, and they are. It is still worthwhile to examine them

on their own, however, because communication is something that can occur in many different ways and may or may not occur within meetings themselves. Meetings provide a setting, also a method and a structure, in which communication may occur. Thus they can be seen as the lifeblood of the organization of which they are the heart, hospitals included. Much of the work conducted to meet the goals of the health care organization occurs in meetings. Their importance over other forums for communication is in bringing everyone involved in a particular issue together, face to face.

Huber (1996) outlines several purposes for meetings which she says include the dissemination of information, opinion seeking and problem solving. Guidelines for conducting meetings include preparation for both the task to be accomplished and for dealing with the people involved. The leader is expected to listen, process interactions, control the flow and keep the group directed toward the objectives (Huber, 1996). Kate's general staff meeting, mentioned under team building, is an example of that. So is her meeting with the materiels management department over the linen shortage, in which she used a blackboard to list the most important points and deliberately kept discussion focused on her basic goal, the reliable provision of resources.

All of the PCMs, however, attended and facilitated meetings of this and several other types. Anne Marie met frequently about downsizing and even conferenced with dietary and environmental staff about their carts. Jackie chaired a meeting on summer staffing. Linda attended a management focus workshop. Kate chaired interdisciplinary meetings. All of the PCMs met often with staff, both about issues related to the provision of patient care and organization of the work place, and increasingly during the time of my

research about the ongoing changes in hospital structure and staffing. And all met with the physicians, their own superiors, colleagues from other areas and institutions, and suppliers of services and resources. Issues dealt with ranged from procedures for handling bereaved relatives of deceased patients to welcoming new staff with cake. Often the PCMs ran from one meeting to another, stopping in their small offices only to pick up files, always organized, always prepared.

5. Coordination. Coordination is an element of the issue of leadership that overlaps with all the rest. It deserves individual treament, however, because if leadership can be seen as a quilt, coordination would be the thread that sews the swatches, the other components discussed above, into one. Haimann (1994) describes it as the process by which managers achieve unity of action in pursuit of common purpose. Hall (1996) calls it an interorganizational process. In this sense, coordination can be seen as the resulting synchronization of efforts, as part of everything the manager does. In a health care context, as the number of positions under the direction of the PCM increases, the greater need for coordination for the achievement of quality patient care becomes apparent.

Coordination of the work environment involved in this study included the following activities:

- ensuring adequate staffing levels;
- involving various disciplines in decisions about patient care;
- facilitating communication between team members;
- designing and implementing budgets and tracking financial resources;

- empowering staff to work autonomously and enhancing individual responsibility;
- establishing and directing work toward goals that promote positive outcomes regarding patient care;
- providing feedback and reinforcement to staff.

It can be seen that these activities embrace planning, staffing and fiscal functions, as well as those functions, such as conferencing, which may appear as more directly related to patient care. This illustrates the dual function of patient care managers discussed by Duffield (1991), as the PCMs participating in this study maintain close contact with patient care while maintaining operation of a myriad of administrative duties.

Downsizing

The second prominent issue impacting on the complexity and pace of the PCM's workworlds is the process of downsizing. In the previous chapter, this issue was discussed as clouding the work lives of the participants and the entire study. Also a brief sketch was given on what it means to the PCMs. In this chapter, however, this issue will be broken down into five components in an attempt to catch a glimpse of the reasons for the effect of downsizing.

To begin with, though, it is important to understand that, as the organizational structure of the hospital in question began to change, a major difference for the discipline of nursing within it was that the office of Vice-President, Nursing, became the office of Vice-President, Patient Care Services. Disciplines other than nursing were added to the purview of this office, as can be seen by referring to the organizational chart comprising Figure 3. As was mentioned earlier, the number of mid-level managers across the whole

hospital was decreased, the number of beds was reduced and some units were merged. PCMs therefore were required to assume responsibility for larger boundaries and were assigned larger spans of control as non-nursing disciplines fell under their jurisdiction.

"From the manager of one unit," Linda recalls, "I just kept accepting more and more units under my control. As the major changes occurred in this hospital, I had to learn new areas very quickly." The learning Linda speaks of relates to the needs of new and different staff members, the pertinent contract specifications and the nature and demands of their work.

The five components of downsizing to be discussed here include; layoffs, bumping, union negotiations, staff morale and boundaries.

1. Layoffs. As mentioned in Chapter 4, downsizing involves a concept of fiscal restraint that has many aspects, all aimed at reducing the overall budget. For many at the hospital that served as the setting for this research, however, this term and its corollary "restructuring" were synonymous with job losses, or layoffs. To management, who downsized, this meant reduced expenses. To staff, who were downsized, this meant the loss of many things, including security, pride and income. To the PCMs, who had downsizing occurring all around them, this meant the loss of staff, mostly highly skilled nurses, sometimes their friends.

But widespread layoffs have not been confined to health care. Strausen (1989) discussed the ranks of middle management being greatly reduced and estimated that one third of all jobs in this category had been eliminated in the United States of America over the preceding three years. Those remaining, Strausen maintains, are in more demanding jobs. The precise number of

middle managers lost in this organization during restructuring at the time of this research is not available, though it seemed to be considerable. The effect on those who went and those who remained most certainly was considerable too.

"I think it has been very difficult for the people who lost their departments, who lost their supervisers and managers. I think that they lost a lot of identity and were floundering," Jackie reflects.

To the PCMs that participated in this study fell the often incongruous challenge of ensuring the continued provision of quality care to patients while human and other resources were being downsized. Nurses were being laid off in order to reduce the hospital budget. Beds were being closed. Units were being merged. Fewer nurses were needed overall, therefore, and some of the reduction in size of staff may well have been justified. The rhetoric from government spokespersons and agencies reported in newspapers and health authority publications (Capital Health Authority Report to the Public, March 1995; Capital Health Authority Performance Report, June 1995; Capital Health Authority Directional Plan Update, January 1996) was that quality care would be maintained despite downsizing. Restructuring of health services became the cry. Weiss (1992) pointed out that better service with less money simply cannot happen.

2. Bumping. As has usually been the case with nurse leaders of any kind, one of the responsibilities of the PCMs in delivering quality care to patients was to provide the right number and kind of staff at the right place and time. Shortages of staff make this challenging enough in itself. During the course of my research, however, this challenge was compounded by a

phenomenom commonly called "bumping", really a labour relations process derived from a provision in the S.N.A.A. Contract (1994) under "Lay off and recall". Intended to enable an employee in a position already or to be eliminated to replace another with less seniority, bumping actually creates situations where junior nurses with specialized skills learned and honed for use within a specialized area can be replaced by senior nurses from very different areas and to whom their new specialty might be quite foreign.

This process caused the PCMs great concern. As new staff, not of their selection, were transferring into specialized areas on the basis of seniority but without the requisite skills or experience of the established routines, the PCMs feared that quality of care might be jeopardized. Some felt it was. Certainly those "bumping in" did not know the patients well and usually were unfamiliar with the type of care required. Accordingly, the four PCMs spent much of their time telephoning to laid off staff on recall lists in a search for temporary coverage by experienced staff. For those bumping in, orientations and inservice were arranged. Time and money for this was limited, though, so use of unspecialized staff in highly specialised areas could not be avoided. The results were unhappiness among both the staff bumped out and those remaining and, with constant changes, ongoing disruption in the formerly smooth function of the patient care team.

This should come as no surprise. Hibberd (1994) says that the practice of bumping required by collective bargaining agreements during layoffs creates havoc in staffing as more senior members displace their junior colleagues (p. 589). And Tappan (1995) points out that staff who care for patients with similar needs over a period of time become efficient at identifying common

needs and providing specific interventions, providing cost-efficient quality care because the nurse who is accustomed to this kind of patient can accomplish the care more quickly than the one who is not.

3. Union Negotiations. As shown in Chapter 4, most of the PCMs began as nurses. With the exception of Kate, their preparation focused on patient care rather than administration. Yet on top of their concerns for both their patients and their staff, the PCMs in this study were frequently required to deal with labour relations issues arising from downsizing within their areas. This involved them in union negotiations. Both sides to the disputes, union representatives and PCMs, purported to represent the interests of staff nurses. Both had the ultimate goal of minimizing deterioration of patient care. And both conducted themselves in a professional and courteous manner during meetings. Nonetheless, grievances were filed, meetings were called and circumstances of staff assignments and lay offs were often reviewed to be sure those receiving lay off notices were treated in accordance with the provisions of the collective agreements.

> One more meeting today, with other patient care managers to re-examine alternatives to reducing costs by layoffs. [The PCMs] have asked for a cap on the number of people that can be bumped in any one area. The union won't agree to a cap. [The PCMs] discuss the high costs of orientation. Some areas have lost as many as 10 people. Some areas have closed and therefore senior nurses are available to bump. [The PCMs] draw a decision tree to try and think through merging staff from various units or working with "seniority rules". They feel they will face grievances in each case, but are trying to determine the best outcome for the patient (Field notes, 1994).

4. Staff Morale. One of the effects of downsizing has already been hinted at when discussing bumping and layoffs. However, unhappiness on the parts of both those who lost their positions and those who had to work on

in the altered, more difficult, conditions, is only part of the story. Based on the accounts of the PCMs and my own observations of the environments in which they worked, it would not be overstating the case to say that wage rollbacks and the climate of uncertainty surrounding the layoffs wrought havoc with staff morale.

The atmosphere, for one thing, was strained. "... the layoffs," Anne Marie relates, "[were] really threatening to the staff.... Each time we did [them], we were losing at least three or four from this ward...." As Linda pointed out, some staff were immobilized with anxiety and it became contagious. Even those who kept their jobs were unhappy, feeling guilty while trying to show their colleagues support. Nurses worried about their livelihoods discussed the changes at every opportunity. Anne Marie relates that one of the hardest things was to keep staff from talking about such things at the desk or by the elevators. "The grapevine was brutal," she recalls. Something else less obvious but just as insidious was happening too. Usually the youngest nurses went, "your fresh blood" as Anne Marie called them; so much new energy and enthusiasm was lost.

Noer (1993) writes about the survivors left in an organization after downsizing. He says employees are seeking assurance and striving for control in a frightening environment. Insecurity and reduced confidence to manage their own careers is part of what Noer calls survivor sickness. Layoffs drain the work spirit, creativity and production from many organizations. Fatigue, guilt and emotions of fear and betrayal are common (Noer, 1993, p. 89). Part of the role of the manager in these circumstances, he

claims, is to provide information, for which workers have an unquenchable thirst.

This is something the PCMs in this study did well. They related to me, and I personally observed, formal staff meetings, telephone conversations and informal face to face meetings in hallways, all too numerous to count. In each, the PCMs told their staff as much as they knew about the transitions occurring in this hospital. Always they were clear and forthright. But the ongoing process took its toll on them too. "One day," Anne Marie confided, "I just broke down and cried."

5. Boundaries. At the time the field work for this research was conducted, the organizational structure of the hospital in question was in a state of flux. Some major changes had been made already. Others were underway. More transpired later. Eventually even the hospital board that was implementing the transitions under discussion was eliminated as regionalization of health care authority occurred. During my time there, however, decentralization of the pre-existing lines of authority had given a broader span of control to each PCM, which in turn made the promotion of individual decision making among staff essential. Though nurses were gaining autonomy, the PCMs' overall responsibilities were increasing as non-nursing disciplines—environmental services, dietary staff, social workers, physiotherapists, various technicians, occupational therapists and more—also came under their purview. Nursing care and provision of its required resources still occupied much of each PCM's time, but other disciplines needed attention too.

Yet, the increased workload of supervision was not the sole or even the greatest challenge of this transition. Even as demanding, or more so, was the problem of integration of these diverse disciplines as the process of restructuring forced them together and their boundaries began to overlap. Sovie (1994, p. 31) suggests that managing boundary interfaces in circumstances of expanding boundaries is one of the most challenging aspects of the nurse manager role. So it was in this case. Kate, for one, was very aware of this problem and made it clear to nurses that technicians on her units were to be integrated into the team. But perhaps Anne Marie summed it up best:

> So, then the department heads in all the other services were gone: physiotherapy and occupational therapy and social work. Those three areas were okay because they spoke to us and said they would like to look after themselves. They each had a professional council as an advisory committee to deal with concerns. They were independent practitioners. But there was a lot of confusion... about how much responsibility they had. They really were responsible to [the patient care manager] but they still had a department downstairs, so they weren't physically on the unit. We acted more as a liaison with them. Environmental services and dietary were more difficult.... Some of them had these carts. They're like their second little home. They move them around. And if a different relief person came in and moved anything on their cart, they got upset.

Quality Care

The final prominent issue relating to the pace and complexity of the world in which the patient care managers work is one that both affects and is affected by the PCMs themselves, namely quality of care. It was revealed to me through both personal observation and their own accounts that each and every one of the participants had a strong commitment to the overall quality

of patient care provided under their supervision. This commitment was expressed directly and indirectly. It was certainly articulated in purposeful discussion and in chance asides. But it was also evident in the participants' attitudes to their work and those they worked with, in their reactions to situations and events on the units, and in the direction, intensity and thoroughness of their efforts.

Undoubtedly they are not alone in this. Sovie (1994) describes the focus of nurse managers as being on delivery of high quality of care, which in turn results in desired clinical outcomes at controlled costs. Managers occupy a critical role in translating plans into actions that affect the quality, outcomes and cost of patient care. Their work is to coach the nursing staff and to provide resources which result in sound delivery of patient care. The PCMs in this study, however, also had to coach various other disciplines toward a commitment to the same outcomes of patient care, integrate the contribution of each team member and foster a collaborative practice among physicians and all other staff. The boundaries of their role were expanding. Staff and resources were being reduced. The commitment of the PCMs to quality care was becoming increasingly difficult to meet.

"Sometimes you need a reminder that you are here for patient care. Our work seems so removed," Jackie muses. "I used to be a hands-on manager. I could walk away and let the staff run the place," Anne Marie reports of a previous time when the hospital provided support for the evening and night shifts. Now that is gone, so staff call her at home for help with decisions.

The components under this issue include; staffing, research, and education.

1. Staffing. As has been shown by some of the discussion on leadership and downsizing, the availability and quality of staff affects all issues relating to the complexity and pace of the world in which the PCMs work. Certainly adequate staffing is essential to team building and the maintenance of staff morale as staff shortages and practices such as bumping, which may give rise to inequalities in staff capabilities and workloads, create problems for patient care managers and staff alike. Here, however, consideration is given to the relationship between problems in staffing and the quality of patient care.

Yoder Wise (1995) make the point that inadequate staffing has both a direct and an indirect adverse effect on patient care. The direct effect of such inadequacy, either in the number or preparedness of staff, is that the requirements for maintaining quality care simply cannot be met. The indirect effect is that patient care may suffer as overburdened providers of care become overly stressed or unhappy. During the course of this study, the participants expressed concern over both of these types of effects.

Whether and how much patient care actually suffered at the institution in question during or due to the transitions will not be dealt with here, however. There are several reasons for this. Firstly, I suspect that loyalty to the institution in question and a strong sense of professional decorum sealed lips. It is important to remember that visitors are not insiders and permission to investigate is not a license to intrude. Secondly, the efforts of the participants were directed towards preventing a quality of care problem, so a lack of success in this regard might be taken as personal failure. My overall sense was that the PCMs accomplished this goal against the odds. Finally and most importantly, however, the focus of this study is on the participants'

experiences, not on the function of the institution in which they worked. The viewpoints canvassed are anecdotal and numerically limited. So it would be both off topic and speculative to delve further into that question here.

One thing that was very clear, however, was that if patient care did not suffer, one of the reasons for it was that the patient care managers worked extremely hard to avoid deterioration of quality of care in the face of ongoing resource erosion and staff cuts. During my observation, enormous time was spent on the phone, searching for replacements for and of the right kind of staff. A great deal of time was also spent helping staff left on the units to see how reorganization might help them get through the day shorthanded, and coaching those staff who were not yet ready to meet their new work situations' demands. The point of this sub-section, then, is that, whether or not quality of patient care actually deteriorated due to cuts in staffing, these cuts did in fact significantly affect the complexity and pace of the PCMs experiences by adding greatly to their workloads and their sense of concern.

2. Research. Another significant influence on the quality of patient care is nursing research, the importance of which to the support of nursing practice has been clear for some time. In writing about the kind of nursing research that will be needed to support practice as health care reform moves ahead, McCormick (1993) declares that describing what nursing does and evaluating its impact will be important as this profession moves toward the role of participant in, rather than deliverer of, the health care. Research skills will need to broaden, including: training in economics (to analyze large data bases that identify nurses' contributions to health care costs); health services research (to assess the effectiveness of treatment plans on individuals and

groups of patients using organization and pooled societal data); epidemiology (to help understand factors affecting population-based outcome measurement); information science (as widespread systems for monitoring hospital and ambulatory practice patterns and patient outcomes become available); anthropology (for understanding cultural diversity and the effect of beliefs and practices on health care outcomes); and evaluation research (which will demonstrate users, impacts and outcomes). The nursing profession, McCormick (1993) points out, will be challenged to provide research and training opportunities to engage in these research efforts.

All of the PCMs in this study were well aware of the need for the nursing profession to conduct research, as well as of the advances in the whole of health care, and most made contributions in this area themselves. Jackie was involved in a research project on implementation of managed care on selected patient outcomes, for which she set aside blocks of time to meet with other contributors to the project, involved other members of her team and presented a preliminary report on the initial work at a conference. She was also approached about another study comparing two drugs. Kate's and Linda's areas of work also had research ongoing.

3. Education. In order to maintain a high standard of care, staff need high levels of skill. Unfortunately, however, when budgets are reduced, it is often the education budget that is cut first. All very aware of this, the PCMs accordingly made educational opportunities available on an ongoing basis. Jackie taught as the need arose, as when she demonstrated how to start a difficult new intravenous system, having first consulted with a physician on the physiology of the process. Linda set up short inservices on new

equipment for her staff. Kate raised questions of special care for certain patients with hers. Each relied on both her own skills and those of others. A patient educator was available to each area for the orientation of new staff, with whom the PCMs consulted frequently. One issue that was debated was whether new staff members bumping in required three days or only one day of orientation. There were also conferences on specialties staff members were encouraged to attend. The importance of education was always in mind.

4. Support. The impact of the support of patients by nursing staff on the quality of care is so obvious it needs no discussion here. Other participants in the health care process, however, require support as well. The families of patients do, which brings to mind the study by Smelzer and Vicario (1988) previously discussed which looked at the role functions of nurse managers and the time spent on activities which are highly valued. Though one such activity claimed to be highly valued by the participants in that study was the counselling of patients' families, those authors found that the values expressed were inconsistent with time actually spent. In the present study, however, the PCMs spent time with the families of patients as needed. During the period of my observation, Jackie spoke at length with an unhappy relative and arranged to follow up with her staff to bring about improvements; there were discussions about accompanying the relatives of deceased patients to the morgue; and Kate had to deal with a patient who had wandered into the hospital president's office to complain, bringing her back to the unit and settling her down.

But the staff who provide the care need support too. As is the case with all forms of leadership, it is the leaders of the patient care team, the patient

care managers, who must provide it. Each and every one of the participants in this study bent over backwards to do just that, listening to and displaying concern for their staff members, and praising, encouraging and informing them on the units, in formal meetings, in the corridors, in their offices and on the phone. A notable example of this is provided by Anne Marie, who on occasion slept by the phone to coach a nurse through a decision in the middle of the night, then went to work early the next morning just to catch her before she left so she could tell her that she did a good job.

Finally, the PCMs themselves need support too. And, though they occasionally receive some from their staff in return, as was related by Anne Marie, more often it falls to them again to provide it to each other, which they do, as the section on team building details.

Scope of the Role

The second commonality evident from the outset of this research, as discussed in Chapter 4, shifts the focus of this inquiry from the setting in which the patient care managers work to the nature of that work itself. It is the broad scope of the role the participants found themselves playing in the process of delivery of care to patients. Naturally this overlaps extensively with the previous commonality. The workworld participates in shaping the role. And the role helps to shape the workworld. Complexity and scope are inexorably related. Here, however, it is what the PCMs do rather than how many things they do that is examined. And, as with the commonality of complexity and pace, the most influential issues associated with this commonality and their components—transitions, resources and

empowerment—have been identified (see Chapter 4, page 95) and will be enlarged on here.

Transitions

The transitions in the role of patient care manager are best described as paradoxical. They are often subtle on one level, yet glaringly obvious on another. Among the former are the managerial behaviours exhibited by the participants, who were used to having one foot firmly planted in patient care, but found themselves increasingly compelled by the economic and political background of their workworld to move toward an administrative focus and to keep their interactions with direct patient care brief at best. Among the latter are the wide range of disciplines and activities they supervise and the sheer weight of the responsibilities they bear.

1. Changes in the Role. From early times when a nurse "in charge" was responsible for both the administration of a ward and the care of the patients on it (Holt, 1936), nurses have tried to perform both of those functions. According to Johnson (1995), this dual focus has emanated from direct hands-on experience and a belief or perception that bedside patient care is central to decision making. But the achievement of balance and quality in performance of both functions has long been an issue in health care administration. Concern over it, specifically about the head nurse moving away from the bedside and focusing on non-nursing duties, was raised in the Ministers' Conference (1961) in Alberta. Then, as hospitals and health teams expanded in the 1970s, administrative duties grew, requiring delegation of patient care to others (McKillop, 1970). Still, authority and much of the decision making

remained with the nurse in charge (MacPhail, 1988), so nurse managers did not move as far from the bedside as they might have.

Now, however, as decision making is being decentralized firmly, a marked transition in the role from the bedside into administration alone is becoming clear. Certainly it is evident in the role of the PCMs. Rather than making decisions on patient care herself from her home at night, undoubtedly the quickest and easiest thing to do, Anne Marie coached her staff to make them. Otherwise her staff would not learn to make them and she could not make them all. All the others coached too. And both Kate and Linda used role-playing to rehearse with staff members autonomous decision making for certain situations.

One of the results of this transition is that classical organization theory, from which much organizational structure and behaviour has derived, no longer applies to the work of the PCMs. The hierarchy of this hospital is no longer vertical. Authority no longer rests solely at the top. The environment is no longer stable and predictable (Sullivan & Decker, 1988). Beyers (1995) has noted a shift from traditional management behaviours of planning and implementing to coaching, facilitating, decision making and playing as a team. In this case specifically, the PCMs are now making decisions formerly made by offices for nursing administration, which are now gone, so it is up to them to develop their staff to make the type of bedside decisions they once made themselves.

2. Professionalism. The essence of the profession of nursing has always been that of delivering or supervising patient care at the bedside (Johnson, 1995) and a core value of the profession is that of caring. Therefore, those

who experience transitions in their roles may also need to undergo transitions of professional identity. Knox (1995) suggests a new professional identity paradigm for the current dynamically changing health care environment, the key to which lies in increasing the value of one's management and leadership skills, knowledge, versatility and flexibility, and their contextual applications (p. 64).

This is a very significant issue for the participants in this study. All are highly professional in their conduct. All are sensitive to the need for and active in furthering the competence of their profession through research and continuing education. And all are committed to quality patient care. But, though all have been removed to a considerable degree from the direct and tangible provision of that care at the bedside, only Kate, who began with an administrative background, consistently articulated a sense of professional satisfaction in the exercise of her administrative skills, even suggesting that her interest in her position would end when the transitions were over. The others, who began as nurses, expressed some dismay at the growing gap between them and the bedside. It might be helpful to them, therefore, to draw on Knox's paradigm as a basis for gaining professional satisfaction, and to remember the suggestion of Gardner and Gardner (1992) about deriving meaning from the exercise of team building skills, as discussed earlier. All of the PCMs have good reason to take enormous professional satisfaction from the realization that it is upon their leadership skills that patient care ultimately depends.

3. Feeling and Emotions. The emotions inspired by the transitions under discussion were sometimes evident as undercurrents, but often ran

high. Feelings were varied, frequently unanimous and sometimes intense. There was anger at times (Kate and the turnip truck). Jackie expressed sadness for the system. There was concern, even tears, for those laid off. There was worry about providing the right kind of staff and the effect of the changes on patients (Linda and Kate). And there was on the part of all frustration with the ever increasing burden of responsibilities and the reductions of resources.

The point that these feelings and emotions illustrate most clearly is that these patient care managers place great value on the relationships that are built up and maintained between themselves as managers and their staff. It is extremely difficult for them personally when those who have earned their trust and loyalty are laid off. Their feelings are sincere. They hurt. They maintain a professional countenance, but they cry either outwardly or inside for those who are forced to leave. And this is how it should be. Trofino (1995) emphasizes the importance of developing relationships with nursing colleagues as one of the skills necessary for future nursing practice. Relationships are important. Demonstrating this is important too. Therefore feelings and emotions and their expression are a significant part of the PCM's role.

4. Coping Abilities. Another aspect of the transitions in the PCMs' role is the ability to cope. It is no exaggeration to state that the number of issues faced by the participants on a daily basis and in their work lives as a whole seemed truly staggering. On top of this, continuing changes rendered conditions uncertain. Conflicts between staff members were numerous. And reduction of resources, especially in the numbers and kinds of available staff,

was a pressure in itself. All of this echoes the work of Hogan and Boss (1993), who found that dealing with staff conflicts caused frustration, and that of Frisch et al. (1991) who described uncertainty, concern about competence and insufficient resources as sources of workplace stress in the head nurse role. Both of those studies related to first-line managers, but may have application to mid-level managers all the same.

In any event, the pressure on the participants in this study caused frustration and distress. Linda and Kate talked about fatigue. Jackie described a feeling of tightness in her chest. Anne Marie talked about being reduced to tears. However, this does not imply inability to cope. On the contrary, it was very much my impression that the four of them coped extremely well. I came to regard them as very special people who may have felt at times that they were bending, but didn't break. Ultimately, the challenges they faced were met. They began early when it was usually quiet, organizing the day ahead. They worked long hours, "Till it's done. Or I collapse. Whichever comes first," as Linda put it. Or, in Kate's words, they did what must be done "one day at a time". They delegated, coordinated, mediated and guided. As Anne Marie said, "Prioritize and delegate. It becomes vital to your existence." They also coped by supporting each other, as discussed earlier. And, as related in Chapter 4, each had her own way of relieving stress—biking, stairmaster, partying, family time—when the work day was done.

Resources

The management of resources was an issue that had tremendous implications for the widening scope of the role of the PCMs. The concept of

resources itself is one of broad scope. Resources are part of the foundation of any health care delivery program. Patient care and the whole functioning of every unit depends upon it, for the concept of resources includes fiscal resources, personnel, equipment and supplies.

1. Providing Resources. As discussed in the previous chapter, it was part of the responsibilities of each PCM that participated in this study to ensure the provision of adequate resources of all types for the areas and disciplines under her supervision. This was not unexpected. Authorities have recognized that mid-level managers are responsible for outcomes achieved by care deliverers (Barnum & Mallard, 1989), for operational, support and administrative components of hospital services (Sullivan & Decker, 1988) and for ongoing development in areas including resource management (Dunne et al., 1988).

The burden of this responsibility was compounded in this case, however, by the fact that policies of economic restraint associated with downsizing had rendered the management and efficient use of resources a high priority during the time of this study. This was true of resources of all types, though much of what has been reported here has related to staffing. And those resources were often scarce. Thus Kate had to wheel and deal for items of supply in every day use. Linda and Jackie had to struggle daily to maintain an adequate complement of staff. Kate was even "reduced to raiding resources", such was the importance of as simple an item as linen in the provision of care. These and other stories recounted by the PCMs concur with the literature on the point that resource management ranks high in the order of skills contemporary nurse managers require.

2. Integrating Work Groups. Another important skill the PCMs required, as touched on earlier under team building, was the ability to integrate various disciplines into work groups as decentralization took effect. Building cohesive work groups was also one of the skills found to be necessary for managers by Vance and Wolf (1986). It was a requirement the PCMs were aware of and found challenging. For one thing, staff volume rose as disciplines were merged. "It became a real challenge to remember all the staff you have to talk to," Jackie mentioned. Staff diversity was a challenge too. All the differing nuances of expectations, capabilities and traditions of various disciplines needed to be understood, especially as boundaries overlapped, as discussed earlier in this chapter. "Physiotherapy, occupational therapy and social work...were independent practitioners, but there was a lot of confusion about how much responsibility they had," Anne Marie remembers, adding, "Environmental services and dietary were more difficult. They weren't used to operating independently." This is where team building skills were so important. Formal meetings were held. But the occasional coffee and cake gathering helped too.

3. Organizational and Nursing Goals. Resources have a purpose. They are used to achieve certain goals. In the case under consideration, none of goals of the hospital in question changed with the transitions of flattening the previously vertical organizational structure, decentralization of authority and reduction in numbers of managers and staff. Both the organizational and nursing goals remained the provision of quality patient care. This presented the challenge, therefore, of meeting those goals with reduced resources and assessing how well those goals are being achieved. Boulerice (1994) outlined

some of the methods developed for measuring pre-established criteria to patient outcomes, including use of narcotic counts, audits and patient satisfaction scales, and has also described the total quality management model (see Chapter 2) as a system-wide effort to improve effectiveness.

The PCMs in this study adopted the premises of team work, continuous improvement and patient focus as they sought more accurate evaluative methods. As Boulerice (1994) suggested, however, there was strain on already heavy workloads as the evaluative duties were added. Serving on a comprehensive committee examining the redesign of organizational activity, the patient care managers had to readjust their work days to accommodate yet more meetings. They also met with managers from other hospitals for comparison of specialty areas, though these meetings were held after normal working hours so daily routines were not disrupted. In addition, there was pressure to reduce the length of patients' hospital stays, so particular kinds of case loads had to be mapped. The goal was still quality care. But the route to that goal was being reworked.

Empowerment

One of the most fundamental issues raised by the broadening scope of the PCM role was the concept of empowerment. As mentioned earlier, the increase and diversification of the participants' workloads required delegation. This in turn demanded independence and autonomy on the part of many different kinds and levels of staff. And autonomy and independence, especially in regards to decision making, depends on capability and confidence. To some extent, these things can be coached.

Empowerment is the overall process of transferring responsibility and capability by which all these elements are promoted, developed and instilled.

1. Coaching Staff. Coaching staff toward autonomy in decision making became an increasingly important and highly visible process at the hospital in question when previously centralized administrative functions such as the nursing office were disbanded. Prior to decentralization, this office had been available as a resource for nursing staff on shifts for which nursing managers were not available for consultation. In such cases, questions relating to media inquiries, viewings in the morgue, or almost anything else could be referred to this authority for help in making the decision. Understandably, many staff members floundered once that source of support was gone. Thus began the practice, detailed earlier, of calling the PCMs for advice at home. Not that the participants begrudged it. On the contrary, they understood and sympathized with it. But the demand on their time and energy was massive and there were times they simply could not be reached. Increased autonomy on the part of the nursing staff and other disciplines was necessary for the good of all involved—the patients, the overall functioning of the units and the staff themselves. The next issue was how to achieve it. This was done in many ways. Kate coached in meetings and on a one to one basis, often using role playing. Jackie did much of her coaching by example on the units. Anne Marie did much of hers on the phone. Each found small ways to help.

2. Conflict Management. The prospect of job loss, overlapping boundaries and scarce resources frequently fosters competitiveness, rather than cooperation, and may lead to conflict. Accordingly, conflict resolution skills become increasingly important. Both Horvath et al. (1994) and Everson-

Bates and Fosbinder (1994) found conflict resolution to be a common practice of nurse managers. And Gardner and Gardner (1992) regard the capacity to deal with conflict as one of the managerial skills that increases over time as the role of manager moves from clinical practitioner to institutional administration.

Such was the case here, as has been related in many of the PCMs stories. Both Kate and Linda described the different kinds of conflict they encountered particularly well. Some of it was with physicians. Other times it was between disciplines. Still more of it was between staff. Some conflict was over apparently trivial territorial issues, such as the arrangement of items on a cart. But other conflict was on a larger, far reaching scale, as union negotiations and the filing of grievances resulted from the merging of units and the laying off of staff. In such instances, strong communication skills, understanding of interpersonal relations, forthrightness and a reputation for trustworthiness were at a premium. The most important point here, however, is not only that the PCMs needed to be and were successful at conflict management, as indeed they were. It is that also they needed to be able to, and actually tried to, coach it. Others needed those skills too. This is what empowerment is about.

3. Advocacy. Empowerment involves more than the transference of responsibility and skills. It requires a voice. And throughout the history of nursing, nurses have often provided this voice on behalf of their patients. They have been advocates for quality patient care. According to Lopresti and Whetstone (1995), the management philosophy of total quality management is based on the premise of finding continuing sources of improvement to

enhance customer service while using resources wisely. This too requires a voice. In the case at hand, the PCMs frequently provided this for both staff and patients. Jackie said, "If I can make life a little bit better for a group of staff, they will make life better for the patients". This is her rationale for advocating for them. She also advocated to her staff on behalf of the family who had been unhappy with a patient's care. It works both ways. And, in the case of the linen shortage, Kate advocated to the materiels management department on behalf of all her staff and patients, in fact, her entire unit.

Who Are They?

The final commonality is perhaps the most difficult to comes to grips with, yet probably the most important. The role of patient care manager could not succeed without strong, competent people to fill it. And strong, competent people need a special role. But delving into the characteristics, background and fundamental nature of a group of individuals is a difficult process and the results are unlikely to be precise. Personality as a concept is complex and resists delimitation. It is exactly this kind of endeavour, however, that the methodology of narrative inquiry suits. Themes can be drawn from the participants' stories. So here the participants will be examined for similarities and differences in their involvement in management, in their leadership and in the way in which they deal with stress.

Movement into Management

As Brighty noted in 1942, throughout the history of nursing development, nurses have been consistent in dividing up tasks in order to do what needed doing so hospitals would function and patients would receive care. However, one nurse was always "in charge" of ward administration (Holt, 1936) and prescriptive routines were derived from physicians. Their influence over nursing is clear. Wheeler (1985) points out, however, that early nurse leaders were neither subservient nor unknowledgeable. Rather, they had vision and struggled to reform both nursing and nursing education. Over time, the role of head nurse or nurse in charge was redefined, but the struggle to retain nurses as central to caring for patients and have others coordinate other duties was maintained (Germaine, 1971) and nurse leaders who moved into the role of administration did so based on their nursing competence (MacPhail, 1988). Often a nurse who was excellent at bedside care would be promoted to be in charge of the ward.

What is evident in the past, then, is that the skills needed for management were assumed to be part of the abilities inherent in bedside care. Often that may have been a valid assumption. And certainly those in leadership positions need thorough familiarity with the work they are to supervise. It has become increasingly clear over time, however, that such skills are not enough. Deliberate education relating to management and leadership is now considered necessary for nurses to become competent managers. For this reason, some universities offering nursing programs have added management courses to their curricula, but only a limited number of nurses have had access to them. And some organizations offer internal

management development courses to help prepare prospective nurse managers to function in complex management practice (Dunne et al., 1988).

1. Opportunity. The stories of the participants in this study reveal that opportunity accounts for their management roles more than long term career planning. Three were promoted to the PCM role from within the organization, based in part on their expertise at the bedside. "Opportunity was put my way," reported Anne Marie. "Staff asked me to apply," said Jackie, adding, "People started to respond to me." "I gradually built my skills," Linda recalled. None of the three planned a career in management. Only Kate did. But they believed in their own capabilities and had already demonstrated their desire to reach their own potential in the profession of nursing. Both Linda and Jackie had pursued further education during their work career, the former obtaining a Master's degree in nursing and the latter a BScN. Anne Marie had considered further education, but had put it on hold to focus on family at this time in her career. The key here, then, is that they did not turn down the chance when it was presented. They were ready for more.

2. Career Planning. As mentioned above, Kate was different in the sense that seeking an administrative position was part of her career planning. She began her education in business administration and, along the educational route, decided she wanted to work in the health care field. "I never wanted to be a nurse, but I wanted to get into that environment somehow," she said. So she became a nurse. But her business background led her into management roles quite quickly. She applied for positions she felt would further her career and enhance her skills, moving on to other

positions whenever she had accomplished what she had set out to. The lifestyle of Kate's husband was an influence here too, as his job involved transfers from one city to another. She felt her education and experience would move well too.

Thus Kate was the only one of the four participants who actually was recruited for the position she now holds. "I got a call one day [in another city] to ask if I would forward a resume and consider coming for an interview," she reports. She did so. And she got the job. Her husband commuted until he was transferred here also. "My husband knows my career is important to me, just as I know his is important to him," she relates. "We don't have kids so it's easier to work out." Of course, this precise role was not envisioned by Kate when she set out. It did not exist in this form then. She did plan for a similar career, however. She knew then where and how she wanted to spend her work life. And she is doing exactly that.

The Individual as Leader

The economic, educational and professional backgrounds that help to situate people such as the participants in their roles, however, are only part of the story of how they came to be where they are and how they function as they do. A number of personal characteristics or responses come into play here, which render such individuals attractive to potential employers and enable them to bear the burdens that inevitably are part of their jobs.

1. Belief in Self. For one thing, those in such demanding roles as the one under discussion here must believe in themselves, as was hinted at by their reactions to their opportunities to become PCMs. Everson-Bates and Fosbinder (1994) write about hiring effective nurse managers as a key to

success of health care institutions, noting that one of the recurring themes is strong self concept. Wolf et al. (1994) report a similar finding, in that the dimensions of a high performance leader included awareness of one's own personal talent, power and contribution to the organization's goals. This sounds like Kate when she says, "I know this will work" or "I know how I get things done and that I will get it done". She has confidence in her own abilities and is willing to say as well as show it. Perhaps she was the most forthright of the participants in this regard, but all of them believed in themselves too, demonstrating this self confidence in how they put forward their views at all levels, in how they planned and in how they followed through. In many cases, this rubbed off on their staff.

2. Hardiness. However, self confidence is not enough. The workworld of the PCMs is full of difficulties and disappointments, as is true of other workworlds as well. Another important dimension of a high performance leader in the profile suggested by Wolf et al. (1994) is hardiness, which those authors define as personality factors reflecting individual commitment, challenge and control. This is a characteristic of all the PCMs. Their commitment, both to the provision of quality patient care and to their profession, is visible daily at the forefront of all they do. Their challenge is to to provide an environment in which their staff can do their jobs in an organization and health care system undergoing major change. Their control is not as clearly seen, as they have many outside influences to contend with. They do contend with them, however. Control is not an all or nothing concept and their contribution was felt. They helped to control the process of downsizing by finding the most humane way of handling layoffs. They stood

up to physicians and managers of other departments. They advocated for their patients and staff. Hardiness is demonstrated simply by the fact that they made their units operate and by the long hours they worked. Only Anne Marie took a buy-out package when it was offered, and in her case it was determination to spend more time with her husband and young children that was the main motivating force.

3. Self Presentation. The need for self confidence has already been discussed. What remains to be said about it, however, is that it is such an important characteristic in a leader that it must be communicated to staff at all times. Details of appearance, manner and speech make leaders look capable and inspire confidence. Smith (1994) writes that as recently as the 1960's the professional socialization of nurses included instruction in manners, deportment and dress and suggests that sensitivity, courtesy and discretion are ingredients of the good manners that are fundamental to managerial communication and performance still. All of the PCMs were very aware of such issues and acted, spoke and dressed accordingly. All presented as if they deserved to be, in the old parlance, "in charge". And deserve it they did.

4. Attitude and Outlook. The attitudes people hold strongly influence their behaviour (Huber, 1996, p. 375). In order to create an climate in which high level performance is delivered, leaders need the cooperation of motivated staff. But Huber (1996) also warns that cooperation is better when stress levels are low and the work level is not overwhelming, and that a climate of trust and both personal and job recognition increases motivation,

which depends in part on how responsibilities are framed. A positive viewpoint may improve attitudes, perceptions and motivation.

This is important for the PCMs, for neither of Huber's conditions for optimal cooperation apply to their situations. On the contrary, stress levels at the hospital in question were disturbingly high and the work demands were rarely comfortable. They approached overwhelming at times. What the PCMs did have on their side, however, was a positive outlook for framing their own and others' responsibilities. This was expressed in part in their focus. "You have to always be focused," Jackie said. It was also expressed in the high expectations they placed upon others as well as themselves. Most importantly, this gained them trust. They recognized staff personally at every opportunity. They supported individual decisions as autonomy in nursing action evolved. Jackie related that she tried not to go to the units except in a positive frame of mind. "I get this burst of adrenaline," claimed Kate, whose staff call her "our own little hell on wheels". She returns the compliment by calling them "WITS", which stands for "Witches in Training". And Anne Marie reported, "I thrive on chaos. I function better when I have a million things to do."

5. Vision. Many of the characteristics of the patient care manager role and the PCMs themselves that have been discussed so far have been described as evident from the outset. One that became apparent more gradually, however, was their possession of a forward looking perspective that here is entitled vision. Initially, any pattern in the activities of the staff was obscured by the bustle of the units. To borrow from Anne Marie, much of the hospital in question seemed to "thrive on chaos". Entering it was in

some ways like jumping onto a roller coaster without knowing how the tracks were designed or where they went. But as I spent more time with the PCMs, a sense of direction grew and the outline of deliberate programs emerged.

Fysh (1984), who studied a group working in the inner city who base their success on a vision, defines vision as "a set of views, based on particular values, directed toward the imagined possibilities of what the future could be." There are two dimensions to this, one of content and one of process. That is, the product of the vision first must be determined. Then a way to develop that product must be designed. Huber (1996) also discusses leaders' vision as shaping values and norms in a way that bonds individuals and groups.

Once again it is Kate who articulates the imagined possibilities of the future so well. "I have in my mind where we need to be," she told me. "I have a plan, a sort of big picture. I know where I need to be, what I need to accomplish in three years." She has, in fact, conceived and is implementing an integrated program from what was formerly a conglomeration of isolated units of care. Much of it results from critical thinking done, due to the nature of her workday, out of conformity with the usual patterns for the development of organizational vision. "I do my critical reflection at 3:00 in the morning," she related, "or driving home or on the treadmill or if I go for a run."

But the others have vision too. Linda is working hard on program development and being visible to the staff, but because full integration is not yet possible, she exercises patience, putting the pieces in place one at a time. Jackie is currently focused on the magnitude of day to day issues which

"never seem to end". Nevertheless, she has a vision of improved patient care and unit management that is not yet realized but to which her research is contributing as she works on.

Dealing with Stress

In the preceding section mention was made of the ability to bear the burdens of the workplace and the need for hardiness in that regard. Despite the obvious resilience of the PCMs, however, I often wondered during the period of my observation how they appeared to function so calmly and maintain such high energy at an exceedingly intense pace, with such a vast and complex range of issues, and during such long hours of work. This is an important issue. Huber (1996) writes that the coping ability of individuals is the major variable modulating stress and its outcome and that evaluating and moderating response patterns reduces distress and enhances sense of self.

Part of the answer, of course, is that the PCMs are, as described above, hardy or resilient. This is something they have cultivated, I think. Huber claims that a perceived sense of control over work related pressures is critical to perceived stress and stress outcomes. Though they are not in total control of the circumstances in which they work, the PCMs deliberately optimize what control they have. Another part may be that when the participants appeared to handle their burden so well, that was just appearance. As mentioned earlier, they present a professional countenance. The underlying reality is that the PCMs, like anyone else, sometimes chafed or bent beneath their burden. Yet another part of the answer is that they resorted to common methods of relieving stress, such as physical activity, which is exemplified by Kate's fitness program, listening to music, or visiting with family or friends.

And a final part, perhaps the most significant, is that they all benefited from each other's support.

1. Fatigue. They all mentioned that they suffered from fatigue. The demands on their time and energy resulted in deep physical tiredness and emotional tiredness as well at times. "I feel really tired, kind of exhausted," Jackie told me. "I need sleep," reported Kate. Linda reported being unable to lift her bike up the stairs. "Quite long hours, and quite draining," said Anne Marie.

2. Isolation. Most of them suffered from a sense of isolation too. "I find it very hard to talk about anything outside of work," mused Jackie. "It's very isolated. I only read the newspapers on the weekend." This is not by choice. The temporal demands of their positions permit little else. Anne Marie handles this in a unique way. She takes what she calls "a cruise day", walking about the units with no fixed purpose, present, available and involved but clearing her mind.

3. Vulnerability. Huber (1996) writes that organizational change and turbulence create stress. Both my own observations and the words of the participants themselves convinced me that the need to deal with downsizing, more than any other factor, induced emotional stress in the PCMs. It brought out in them vulnerabilities I might not have otherwise seen. It brought out Anne Marie's tears and tightness in Jackie's chest. "I was almost sick," said Linda. But vulnerability brings its own rewards as well. During the worst of the layoffs, Anne Marie found small gifts outside her door. "It's draining, but strangely rewarding," she said.

4. Support. The PCMs spent a considerable portion of their time and energy giving support to others—to patients, to patients' relatives and to their staff. But they also received support themselves, which was undoubtedly one of the keys to their ultimate ability to handle their stress. Kate and Anne Marie both talked of their reliance on their husbands. "My husband is my biggest fan," Kate claimed. "My husband is a big support," said Anne Marie, who was the only one of the four juggling children with her demanding career. Jackie and Linda remarked on family support too. "I have very supportive children," the former reported. Several of them also cited the support of friends. But, as related earlier in regard to team building, the four had another source of support able to understand their situations better than anyone else. They had each other too.

Summary

As stated in the introduction, the purpose of this chapter has been to unify and make sense of the narratives as a whole by highlighting, examining and explaining the three previously identifed commonalities and their components within the context of their setting and place in time. Most of this this has not been difficult to do. The experiences of the participants have been consistent. All find themselves in a role of rapidly expanding boundaries and responsibilities, in a work setting of decentralizing control and increasing complexity and pace, and under increasing pressure of fiscal restraint. All are required to make, and indeed are making, the transition from a manager who knows and directs to a leader who coaches and helps to construct relationships and supports.

One thing that has been more challenging, however, was interpreting the commonalities in the PCMs experiences in an orderly fashion and providing explanations for the various influences upon them that were clear and distinct. It was evident throughout the interpretive process that all are related and mutually interdependent. Thus, the broad and apparently broadening scope of the PCMs' role influences the often "incredible" (Dunn & Schilder, 1993) fast pace and complexity of the world in which they work and vice versa. The fast pace at which the work world proceeds enables the scope of the role to be broad. Both the stories themselves and their underpinnings intertwine.

But that is not the whole story. The story tellers play a big part in it too. The natures of the PCMs are as influential as anything else in making their experiences what they are. All of their characteristics—and especially their determination, flexibility, vision and what I came to call "continuous optimism"—allow them to survive their sometimes frantic pace and even thrive in their difficult role. Their leadership, organizational and communication skills help with this too. At the same time, though, their personal success also enables such a broad role and such a fast and complex work world to succeed to the extent it does. By making their role work, the PCMs are to some extent the authors of their own fortune.

But this is true only in part. The breadth of the role itself and the fast pace and complexity of the world in which they work help to shape the PCMs too. These things require them to be what they are and have to some extent wrought in them a change. Although I don't believe the PCMs realized it themselves, I noticed in them a metamorphosis even during the relatively

short time that I was with them which was expressed initially as a shift in attitude toward their role, their staff and themselves. Authority was transformed into autonomy as some of their control was yielded. Right before my eyes, the participants were evolving from managers who had all the answers, made all the decisions and did all the planning, organization and direction themselves, to leaders who fashioned an environment and a framework within which these functions were performed by others. Now the PCMs coached independent decision making, role modelled standards, facilitated communication and built visions and teams.

This intrinsic interplay of the commonalities is not the only influence on the experiences of the participants, however. On the contrary, it was apparent from the beginning of my field work that extrinsic factors affect all aspects of the PCMs role to a very significant degree. Most prominent among these is the economic context and its resulting policies that led to the definition of the PCM role and continue to shape the setting in which the PCMs work. Downsizing was always a key here. Layoffs increase workloads. Coalescing of departments or units intensify internal dynamics. Shortages of resources escalate tension and interfere with the provision of care. All of these things depress staff morale. All create problems for the PCMs to solve. To put it somewhat dramatically, the spectre of downsizing loomed over all.

CHAPTER 6

Reflections

As discussed in previous chapters, it is an aim of this study specifically, as it is of the process of narrative inquiry as a whole, to acquire understanding of how the participants make sense of their experiences. In this study, the participants were patient care managers. But the research process made storytellers of them too, who seek to make some part of themselves or some aspect of their experiences understood. In recording and reporting their stories, the goal of the researcher is to enable readers to understand those stories too, but as a whole, or to "make meaning" of the research text into which their stories have been compiled, as Polkinghorne (1988) puts it. The last chapter served that purpose for the most part. It remains now only to conclude by reflecting on what has been accomplished and by anticipating where it could lead.

Glancing Back

Reflecting back on what has been done serves a dual purpose. It provides a context for summarizing often extensive and unwieldy research findings and for drawing attention to the most significant points that arise from them. But it also provides an opportunity to consider the success of the research effort and the effect of it on those involved. Accordingly, this section of this concluding chapter will briefly review the lived experiences of the PCMs and the most important points that can be drawn from the findings

about the role and the participants themselves. It will also consider the effectiveness of the particular methodology employed—narrative inquiry.

At the Lived Experiences

The similarities in the daily lives of the four participants were not hard to discern. Each had her own special areas to supervise and her own unique people and problems to manage. But each had a huge variety of tasks, disciplines and personnel to deal with. And all arose and went to the workplace early, carried immense workloads for long hours at a frenetic pace ("I do everything the same, flat out," says Kate) through noisy and frequently chaotic circumstances, and returned home at late hours with much of their work incomplete and many problems unresolved. And even then not always were they released from their burdens. Often the phone kept them connected to the workplace throughout the night. This was what led to recognition of the first two commonalities: the fast pace and great complexity of their worklives, and the wide scope of their role. It is a role that was at the time of this research still changing too.

The third commonality was apparent in the participants themselves. Certainly they presented some individual differences, most notably in their educational background, career expectations and preparation for the assumption of a managerial role. But they also were without exception resilient, highly organized, confident people of vision, yet with typically human vulnerabilities too. By their own admission, they sometimes crashed. And they sometimes exhibited some ambivalence toward the demands of their roles. But their ultimate reaction, their active, lived response, to their work was unequivocal and clear. They were passionate about it and deeply

committed to patient care. So somehow they all just kept going, taking it one day at a time. "Put on your running shoes and hardhat," Linda warned me at the beginning of our day. Whatever it took, they simply got the job done.

On the Role

These commonalities, however, still pose three questions. The first is why was the pace of the workplace of the patient care manager so fast, the range of tasks so complex and the role so broad in scope? A complete answer is, of course, beyond the scope of this study which serves mainly to introduce the problem and identify the most important issues. But the findings do hint at some influences, however. The role itself was the product of a number of historical, social and economic factors culminating at a point in time. One was the long term dual focus of the practice of nursing on both patient care and management. Another factor is the long standing dynamics between the medical and nursing professions. Even the availability of people like the PCMs was an influence too. Without those who played it, the role could not have evolved.

But the single greatest influence in shaping the role, I have concluded, was a force that brought all the other factors together and pressured them till something new emerged, much as compression by the weight of the earth's crust over time transforms plant matter into coal. This force was the recent economic climate and related policies of fiscal restraint that led to restructuring of hospital administration and downsizing of areas, departments, resources and personnel. Though this issue never was and is not now the focus of this research, it impacted hugely on everything else: on the availability of resources, on patient care, on both interdisciplinary and

interpersonal interactions, and on staff morale. Everyone was called on to make do with less. Everyone was pressured to change.

On the PCMs' Background

The second question is related to the preparation of the participants for the roles they assumed. Certainly they were required on a daily basis to do a great many things for which they were not specifically educated. As is probably true of most candidates for similar positions, the participants in this study were educated primarily to have a strong background of clinical skills in a variety of specialties, rather than the wide range of interpersonal, fiscal and other competencies the role now demands.

This is not to imply that a strong clinical competence in their background was irrelevant or would be so to patient care managers in the future. On the contrary, the participants needed their clinical skills for supervision of their units, education of their staff and understanding the overall operation of the areas under their management. Accordingly, and despite some current feeling in the health care system that people from disciplines other than nursing should occupy the role, there will always be a need for a strong clinical foundation in whatever specialty or specialties is being managed. Just as managers of any type must be knowledgeable of the areas under their control, patient care managers must be knowledgeable about nursing to be credible to and supportive of their staff, to converse with physicians, and to be able to assess and plan the level of care being provided under their supervision.

One of the main implications of the findings of this study, however, is that the participants would have benefited from, and patient care managers

generally need, much more. Required are a number of characteristics that are combinations of inherent personality traits and learned behaviours: high energy and stamina; patience; confidence; sharp focus at different levels; flexibility; determination; poise; self-awareness, sensitivity, perceptiveness and receptiveness to others; and a strong sense of responsibility. They also need considerable education, skill development and experience in critical thinking, decision making, long term planning, fiscal management, organizational theory, team building, conflict resolution, problem solving, and the dynamics of group process. Also desirable are a working familiarity with the basic concepts, procedures and, where applicable, pertinent legislation and regulations regarding labour relations, occupational health and safety, emergency procedures and disaster planning. Finally and above all, they need excellent skills in communication.

Many of the above elements are capable of being learned or instilled. They could be identified, taught and fostered in educational programs for midlevel nurse managers, perhaps as part of additional degrees sought by nurses with basic undergraduate education. A large component of instructional time would need to be devoted to financial, human resource and material management, decision making theory, critical thinking and communication skills. The great variety of problems, expectations and demands to be faced in the role could be touched on in a course on "issues". Lastly, a substantial practicum, pairing students with current practitioners of nurse management in active settings, would be the most important feature of all.

At the Participants Themselves

The final question is why were the participants in this study able to handle such a demanding and changing role as well as they did? After all, their roles, their workplaces and they themselves were all in transition as they changed from nurses, influenced by traditional patriarchal culture (Duchscher, 1994) to midlevel managers in formal, delegated positions of authority. They managed the resources and environment of an area or areas so that nursing care could be provided efficiently, effectively and in accordance with the goals and objectives of the organization. They required competence, they required authority, commensurate with the delegated level of accountability and they accepted the responsibility for the functions of their position. Changes occurring in the health care system demanded that they take on greater responsibility and wider ranging scope of practice than ever before. The pace at which they worked and the complexity of the issues with which they dealt must have seemed overwhelming. And the challenge they faced of maintaining exemplary patient care and staff morale under conditions of fiscal restraint and downsizing was immense.

After much observation, review of interviews and thought, I have come to attribute the PCMs' success to the possession and cultivation of several personal characteristics rooted in their inherent personalities but also deliberately or incidentally developed in response to the demands of the role. The most obvious is sheer determination. No one would survive professionally in their circumstances without it. Another is the ability to focus, to compartmentalize demands on their energy, attention and time and other aspects of work and personal life to their appropriate places and times,

and to concentrate fully on the task at hand. A third is flexibility or adaptability. As their responsibilities grew, their thinking and behaviour were transformed, leaving them able to handle change more comfortably than most of their staff, who lagged behind. A fourth is the ability to see the larger picture, to anticipate and plan in such a fast-paced, urgent world. I call this vision. Finally, there is what might be called a sense of balance, a type of perspective that enabled them to maintain their sharp focus and wider vision simultaneously and to operate on different levels in the midst of change. It was this that most clearly distinguished the PCMs most from even their most competent staff.

On the Methodology

In any research endeavour, it is always important to look back at the methodology employed and reflect on its advantages and limitations. It is only by so doing that methodological rigour in individual work is guarded and advanced and that research as a whole maintains or improves its validity, thoroughness and significance. In the case of this work, the methodology of narrative inquiry was used. A research setting was arranged, study participants were selected from available patient care managers. They were interviewed and observed; field notes and interview tapes were compiled, transcribed, and validated by the participants and corrected as required; a research text was constructed in story form; and this text was reviewed with a view to discerning patterns and themes.

One of the major advantages of using this methodology is that the material gathered, as well as the workworld from which it was drawn, was experienced in a highly personalized way by me as a researcher, allowing me

to see, hear and feel the work lives of the patient care managers myself. This hearkens back to Chapter 2, in which it was said that the everyday realities of nurse managers are captured through their practices and pragmatic concerns. Diekelman (1990) also wrote about the importance of listening to the voices of others in order to gain the connectedness that guides the practice, teaching and research of nursing. In any event, the experiences of the PCMs certainly came alive for me, and hopefully the same will be true in some degree for readers of this dissertation.

Another advantage made clear to me through growing familiarity with this methodology is that it fosters trust and the consequent disclosure that is so critical to opening up the participants' inside world, thus providing insights unlikely to have been gained through other forms of research. In this regard it is important to distinguish between the various benefits of research. Narrative inquiry may not have great probative value. Its results are not decisive and precise. But its descriptive value is high. Best suited for preliminary investigation of new areas and issues, it can, when properly used, uncover insights which point to research pathways and lead to discoveries on which further inquiry can be based.

This methodology is best suited to small sample sizes. It follows, therefore, that transferability of the results and the insights so acquired may be limited. Although the selection process in this study was directed toward choosing participants from a variety of areas so that a wide variety of viewpoints and experiences would be represented, the managers studied here still might not be typical of their kind. The role itself might not be typical of midlevel management elsewhere. The economic climate that pervaded the

hospital and research setting might have created conditions atypical of other circumstances and times, thus skewing the perceptions in the minds of the participants, the researcher and ultimately any readers. The usefulness of the findings will be determined by other readers who may find similarities in other practice settings. If the discussion reflects reality for the reader understanding will be promoted.

This limitation is cause only for caution, however, not for dismissing or taking lightly the results of narrative inquiry research. The drawbacks of small sample sizes are considered less significant today than they were at one time as recognition grows that the information they yield can augment other research and contribute to a body of knowledge as a whole. Connelly and Clandinin (1990, p. 3) write that by understanding narrative life experiences we learn to understand ourselves, our students and our colleagues. So, if any reader—whether educator, patient care manager colleague, student or a nurse who is considering a similar role—recognizes in these stories anything akin to something in their own lives or in the lives of someone they know, then meaning has been shared and the purpose of this work will have been fulfilled. From the reactions of the participants themselves to the texts they were asked to validate, I think some sharing of meaning has already been achieved.

Overall then, the methodology in this case has facilitated the revelation and explanation of critical moments or events in human interaction. As Polkinghorne (1988) says, we cannot but be stronger for understanding the worlds in which each other lives. Hopefully, this will lead to strength and unity among nurse managers too.

At Myself

This study depicts both a role and a group of people in transition, but it also initiated an overwhelming transition in myself. The initial intent for undertaking this research was to upgrade my education and to discover new and better strategies for teaching nursing management to emerging graduate nurses. The work of eliciting, reconstructing and interpreting narrative, however, helped to free me from the usual deductive framework for both thinking and teaching and led me to rediscover the power of story and the value of listening to what others have to say.

The implications for how I will teach or facilitate learning in the future, then, are clear. Theory will be linked with practice. Listening skills will be emphasized, practiced and reinforced. The sharing of stories between students, teachers and participating practitioners will be encouraged. Clinical practicums matching students with nurse managers will be an important part of my nurse management teaching, which will include seminars in which group members will be asked to share their stories of the day; input will be sought from others and observed practice will be discussed. Students will be helped to find meaning in their own experiences and in those that others share.

> I have watched, heard and listened. I cannot help but be a better teacher for this experience. In keeping with the high standards set by these four PCMs, I will reach out to prospective students in management and will use stories from the real world to discuss management of nursing in the 1990's (Field notes, August, 1994).

Looking Ahead

Both change itself and the recording of change can be difficult. All changes, no matter how small, impact on others, and those on others in turn,

so that transitions in small structures provoke transitions in large ones, and vice versa. This study has established that the pervasive changes occurring throughout health care services in the Province of Alberta are clearly reflected in the benchmark hospital that served as the setting for this research and have already brought significant change to the definition of roles within that institution as well. This work focuses for one brief period of time on one small but key role in service provision which has undergone and is still undergoing change. The patient care manager role is one that has grown, and is still growing, from a senior nursing position to a true midlevel managerial position, with all the fiscal, material, human resource and other responsibilities such positions entail.

The nature of the work of such managers at this particular acute care hospital at this point in time was vastly different—more complexity, more intensely paced, and much wider scope—from equivalent roles in the past and from roles the participants themselves were used to. Accordingly, these professionals have been called on to carry out duties and meet expectations requiring a broad, and ever broadening, range of skills and the development of critical thinking to a very high level. So far, due to the unique qualities discussed earlier, they have managed to do it. But, if change continues at its present pace, even those qualities may not be enough. Moreover, if this is a proto-typical role, and if the demands of the role keep on expanding, educational requirements will need to be enlarged and refined to keep nurses well suited for and comfortable with management practice. Preparation will be the key.

I wrote in my introductory chapter that I hoped the reconstruction of the participants' narratives would lead to insight for future managers as well as for curriculum design. In this regard, I hope and believe that the stories and reflections shared here may persuade nurses and students to engage in career planning from a very early stage of their educational and professional development and to become well acquainted with what is involved in the roles they aspire to. Certainly, some midlevel management instruction should be acquired along with basic nursing education. And for those who decide to aim for management careers, in depth practicums are essential.

Also, the nature and scope of the work identified here indicates that the role requires broader knowledge and skills than are currently part of nursing management curricula. Accordingly, in addition to the remarks made on nursing education in the previous section, I make the following recommendations for future development of nurse management programming:

1. Continued examination of the patient care manager role through additional research at the institution studied in this research and other institutions should be carried out to provide a foundation of knowledge for analysis of the role and for curriculum design. This should include quantitative studies deriving from these findings but looking at the same commonalities to learn if the activities of the PCM role have stabilized and/or are continuing to accelerate.
2. A model for the patient care manager role should be developed and shared with interested organizations, identifying and promoting criteria and qualities needed in this role to facilitate career planning.

3. Design of a program of studies to prepare students for contemporary mid-management roles in the health care system should be embarked on, including the following elements:
   - development of a conceptual framework;
   - collaboration with practitioners of nursing management;
   - incorporation of the advanced skills and knowledge needed for the role, based on the model developed for the PCM role;
   - instructor supervised practicums with current nursing management practitioners.

Summary

The lived experience of four patient care managers in one acute care hospital has been observed and described using the methodology of narrative inquiry, which has been a lived experience in itself. The role has been found to be in transition, shaped by transition and provoking of transition too. Ideas for career planning and curriculum design are beginning to emerge. Hopefully, both understanding and more inquiry will result.

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Appendix I

Role Description: Patient Care Manager

The role of the patient care manager is a fast paced, diverse and complex role, set in a dynamic complex organization. The facilitation of exemplary care in keeping with the organization mission involves a high level of accountability for both leadership skills and management practices.

The role involves team interaction with multiple persons, departments and disciplines.

Key responsibilities

1. Leadership skills
   - develop a team vision in concert with the organization mission.
   - facilitate the continual growth and capabilities of team members.
   - shape the evolution of a culture for the work team.
   - foster decision making in a shared ownership environment.
   - promote motivation and education.
   - develop, facilitate and disseminate research and research findings.
   - promote professional and personal growth.
   - promote management/union collaboration.
   - develop critical thinking, based on reflection and analysis.
   - continual striving toward a more productive organization.
2. Managerial, business skills
   - interaction with, and availability to patient care area.
   - fiscal management.
   - human resource management.
   - environment resource management.
   - facilitating the availability of supplies and equipment.
   - management of time.
   - management of information—process and dissemination.
   - networking.

- committee work.
- project development specific to each area hospital wide/external.
- identification of trends and issues in respective areas and programs.
- Facilitate marketing.
- public relations.
- reports, memos, data collection.
- t q.m / risk management
- accreditation standards.

3. Interpersonal skills
   - team building.
   - problem/conflict resolution.
   - advocacy—medical, ethical, legal (patient & staff).
   - collaboration.
   - coach, guide and promote the growth of team members.
   - performance appraisal process.
   - communication—written, verbal.
   - peer support.

Draft role description, U of A Hospitals. March 11/94.

Appendix II

Informed Consent

University of Alberta

Faculty of Educational Administration

Project Title: The lived-experience of the patient care manager

Investigator: Georgina Fysh, Phone 434-0038

The purpose of this research project is to gain in-depth understanding about the lived experience of the patient care manager. Non-participant observation and interviews with the patient care manager will be carried out in order to gain knowledge about the experience. The interviews will be tape recorded, but will not be shared in any way except via the final report. Anonymous quotations will be used. Each patient care manager will have the opportunity to read the transcriptions prior to publication.

This is to certify that I, _____, hereby agree to participate as a volunteer in the above named project.

I hereby give my permission to be interviewed and for these interviews to be tape recorded. I understand that at the completion of the research, the tapes will be erased. I understand that the information may be published, but my name will not be associated with the research.

I grant permission for observation of my activities. I understand that I can ask the researcher to leave at any time if I do not want observation of any particular activity.

I understand that I am free to deny any answer to specific questions during the interview and further, that I may withdraw my consent and terminate my participation at any time without penalty.

_____	_____
participant	witness
_____	_____
researcher	date

Appendix III

Semi-structured interview guide

This research is being undertaken to gain understanding about how you experience the world in which you operate as a patient care manager. I want to hear your stories, to reconstruct your stories, and to share them with others who may learn from them.

1. Let's begin by talking about how you came to be a patient care manger in this hospital (background, education, life events).

2. Let's walk through a day in your life at work.

3. When you assumed this position did you realize what was involved?

4. Can you tell me about some of the experiences (good vs. not so good) that stand out about the role?

5. How do you feel about the multiple role responsibilities?

6. How do you make sense out of this management practice?

Sub questions may arise from each of these, or successive questions which cannot be identified at this time.